

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																																
<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> c. LENGTH OF STAY IN 1b <u>LIFETIME</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL GEN. HOSP.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> d. STREET ADDRESS <u>19 MARLEY NECK RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																										
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CLYDE</u> Middle <u>ADAM</u> Last <u>ABEL</u>			<b>4. DATE OF DEATH</b> Month <u>JAN</u> Day <u>14</u> Year <u>1966</u>			<b>5. SEX</b> <u>MALE</u>			<b>6. COLOR OR RACE</b> <u>WHITE</u>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>Nov. 25/1896</u>			<b>9. AGE</b> (In years last birthday) <u>69</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																														
Months	Days	Hours	Min.																													
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CONTRACTING</u>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BALTIMORE, MD.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>																				
<b>13. FATHER'S NAME</b> <u>George A. Abel</u>						<b>14. MOTHER'S MAIDEN NAME</b>																										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <u>217-05-4342 A</u>			<b>17. INFORMANT</b> <u>(Mary A. Abel</u>			<b>Address</b> <u>19 Marley Neck Rd</u>																				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u> <u>years</u>																				
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>																		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)																								
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1-13</u> , 19 <u>66</u> , <b>to</b> <u>1-14</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>1-14</u> , 19 <u>66</u> , <b>and that death occurred at</b> <u>1 P.M.</u> , <b>from the causes and on the date stated above.</b>																																
<b>22a. SIGNATURE</b> <u>Ernest A. Leipold</u>												<b>22b. DATE SIGNED</b>																				
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Ernest A. Leipold</u>						<b>22d. ADDRESS</b> <u>425 Ritchie Highway S. E.</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>																								
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>1/17/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>																						
<b>24. FUNERAL DIRECTOR</b> <u>Raymond C. Fink</u>						<b>ADDRESS</b> <u>Glen Burnie, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 17 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>																						

A 1471-20-2000

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

00084

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00083

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Childrens Center Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donna</u> Middle <u>M.</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/54</u>
9. AGE (In years lost birthday) <u>11</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John B. Adams</u>		14. MOTHER'S MAIDEN NAME <u>Gwendolyn M. Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>John B. Adams</u>		Address <u>1613 V St., N.W.</u> <u>Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>9027</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Atrophy -</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Rebound on chair + slid under rear branch</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1-1</u> p.m. <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Childrens Hosp</u>		20f. (City or town) (County) (State) <u>Alto MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>1-1-66</u>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		M.D. <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/7/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
<div style="display: flex; justify-content: space-between;"> <span>00085</span> <span>Item #9 Willm 40372 1/11/66 pc</span> <span>00084</span> </div>									
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>ANNE ARUNDEL</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Thon Burnes</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lithicum HTS.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>North Arundel Hospital</b>					d. STREET ADDRESS <b>307 Catherine Ave</b>				
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>G.</b> Middle <b>AMEND, JR.</b> Last					4. DATE OF DEATH <b>Jan 9 1966</b> Month <b>Jan</b> Day <b>9</b> Year <b>1966</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) <b>48</b> yrs. IF UNDER 1 YEAR: Months <b>02</b> Days <b>1</b> IF UNDER 24 HRS: Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Air Craft Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles G Amend Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Anna L Edelmann</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>216-01-4807</b>		17. INFORMANT <b>Mrs Sophia Amend</b> Address <b>307 Catherine Ave</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>ARTERIOSCLEROTIC Heart Disease</b>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1965</b> , to <b>Jan 9 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 9 1965</b> , and that death occurred at <b>530 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Joseph Taler</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan 9, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>					22d. ADDRESS <b>95 AQUAHART Rd. Glen Burne, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc</b>					25a. REC'D BY REGISTRAR <b>5305 Harford Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		

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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00086 <span style="float: right;">00085</span>											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>						c. LENGTH OF STAY IN 1b <u>8 DAYS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSPITAL</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHADY SIDE, Md 02-1</u>					
d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MATILDA</u> Middle <u>WINTER</u> Last <u>ARCHER</u>						4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-10-87</u>		9. AGE (in years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Franz Winter</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>William H. Archer, Jr</u> Address <u>5219 Vernon Dr Camp Sp Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Recurrent metastatic carcinoma skin from breast</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) <u>Dr. Martin T. Kim</u> attended the deceased from <u>1-10</u> , 19 <u>66</u> , to <u>1-18</u> , 19 <u>66</u> , that (2) <u>  </u> last saw the deceased alive on <u>1-18</u> , 19 <u>66</u> , and that death occurred at <u>11:45</u> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Martin T. Kim M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/18/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Martin T. Kim, M.D.</u>						22d. ADDRESS <u>Shady Side, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1-20-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St James Church Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Lothian Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland</u>						25a. REC'D BY REGISTRAR <u>JAN 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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2-10-87 48  
 Winter Archer  
 1 18 66  
 2 days  
 2 days  
 2 days

Hypertensive (cardiovascular disease)  
 (congestive heart failure)  
 10 days

1-18 66  
 1-10 66  
 1-18 66  
 1-18/66



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CERTIFICATE OF DEATH

Reg. Dist. No.

00087

00086

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>			
c. LENGTH OF STAY IN 1b <u>10 YEARS</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 90-A Route 5</u>				d. STREET ADDRESS <u>Box 90-A Route 5</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES LESTER ATKINSON</u>				4. DATE OF DEATH Month Day Year <u>JAN 1 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 27, 1925</u>	
9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>ALFORD CLYDE ATKINSON</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA ERNESTINE HALES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1943-</u>				16. SOCIAL SECURITY NO. <u>216-16-2482</u>		17. INFORMANT Address <u>WALLACE ATKINSON PASADENA MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA (BRAIN) - METASTATIC</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA LUNG.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 WEEKS</u> <u>3 MONTHS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>DEC. 20, 1965</u> , to <u>JAN. 1, 1966</u> , that I last saw the deceased alive on <u>DEC. 28, 1965</u> , and that death occurred at <u>2:35 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9471 FT. SMALLWOOD ROAD PASADENA, MD.</u> DATE SIGNED <u>1/1/66</u> ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D. PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George J. Gonce 4001 Ritchie Hwy. Baltimore 25, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 4 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

# CERTIFICATE OF DEATH

00001

00000

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIED		SINGLE	
EDUCATION		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>				d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Moore Rd Rt 1 Box 434</u>						d. STREET ADDRESS <u>Rt 1 Box 434 Moore Rd</u>					
3. NAME OF DECEASED (Type or print) <u>Edward Frederick</u>						4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1886</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Steam Fitter - Heating</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Fred -</u>						14. MOTHER'S MAIDEN NAME <u>Clay J. L. Reibel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>Gene Ay Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>A.C. V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Senility</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>  </u> , to <u>1966</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>12-31-65</u> 19 <u>  </u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert R. Holm</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-4-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>						22d. ADDRESS <u>P.O. Box 73 Severna Park Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>1-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (city, town, or county) (State) <u>Baltimore Md</u>			
24. FUNERAL DIRECTOR <u>Robert S. Banawo</u>						ADDRESS <u>Severna Park Md</u>		25a. REC'D BY REGISTRAR <u>N 5</u>		25b. REGISTRAR'S SIGNATURE <u>1-5-66</u>	

MEDICAL CERTIFICATION

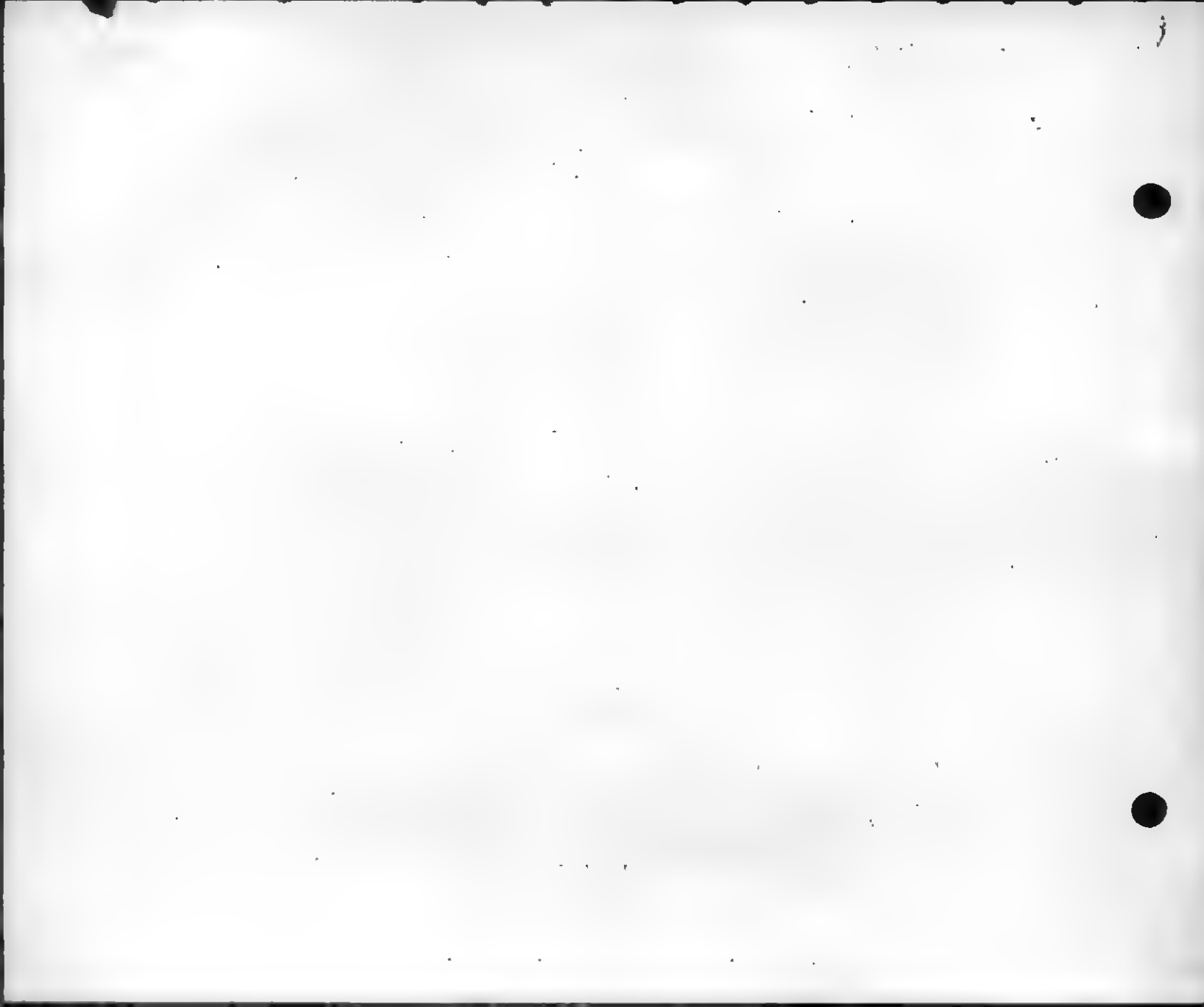


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal (and in any event, within 72 hours after death).

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00089 CERTIFICATE OF DEATH 00088									
Item 7 Film 575 2/10/66 mb									
1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY +1				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 18 yrs. 7mos		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Princess Anne, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital					d. STREET ADDRESS Unknown			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #11076 James			First Middle Last Bailey		4. DATE OF DEATH Jan. 29 19 66		Month Day Year		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 60 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 4 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -----					
20c. TIME OF INJURY Month, Day, Year How and p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/4, 1948, to 1/29, 1966, that (I) (we) last saw the deceased alive on 1/29, 1966, and that death occurred at 3:40 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Daniel McHenry Mapp, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/2/66	
22c. PHYSICIAN'S NAME (Type) Daniel McHenry Mapp, M.D.				22d. ADDRESS Crownsville State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 2/4/66		23c. NAME OF CEMETERY OR CREMATORY University of Md.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Wm Reese II - 108 W. Washington St., Annap.					ADDRESS		25a. REC'D BY REGISTRAR FEB 7 1966		
							25b. REGISTRAR'S SIGNATURE [Signature]		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, the certificate should be removed from the file and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00090 CERTIFICATE OF DEATH 00089											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAYO</u> c. LENGTH OF STAY IN 1b <u>GERMANTOWN RD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GERMANTOWN RD</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAYO</u> d. STREET ADDRESS <u>GERMANTOWN RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRUCE MINEAR BAIRD</u>						4. DATE OF DEATH Month Day Year <u>JAN 27 1966</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 3, 1906</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RADIOLOGICAL ENGINEER U.S. GOVMT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>KEOKUK IOWA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>DR. JAY BAIRD</u>						14. MOTHER'S MAIDEN NAME <u>IDA MINEAR</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>448-09-4204</u>		17. INFORMANT <u>MRS. GWEN M. BAIRD # 2</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant tumor of brain</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1965</u> to <u>Jan. 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan. 16, 1966</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/27/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. TAYLOR</u>						22d. ADDRESS <u>302 ANNAPOLIS MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-29-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MAYO MEMORIAL CEM.</u>				23d. LOCATION (City, town or county) (State) <u>MAYO, A.A. Co. MD.</u>			
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR</u>						25a. REC'D BY REGISTRAR <u>Feb 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

1. The first part of the document is a list of references. The references are listed in a standard format, with the author's name, the title of the work, and the publisher. The references are as follows:

2000-2001

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00091

00090

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA Co</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA Co</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> d. STREET ADDRESS <u>Rte 1 Box 305</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>James</u> First <u>Earneſt</u> Middle <u>Baker</u> Last			<b>4. DATE OF DEATH</b> <u>Jan. 8</u> Month <u>1966</u> Year		
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>Feb 12, 1884</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>carpentry</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Shipbuilding</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Edgewater, Md</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>318-05-2772</u>		<b>17. INFORMANT</b> <u>Rte 1 Gladys R. Baker Edgewater, Md</u> Address <u>Box 305</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Generalized Arteriosclerosis and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>NEED</u> (c) <u>Carcinomatosis Primary to Cancer of prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>24 hours</u> <u>8 years</u> <u>5 years</u>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March</u> <u>1966</u> , to <u>Jan. 7</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 8</u> <u>1966</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Sylvia M. Lim</u>			<b>22b. DATE SIGNED</b> <u>1/8/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Sylvia M. Lim</u>
<b>22d. ADDRESS</b> <u>Rt 1 Box 244 Edgewater, Md.</u>			<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-11-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St Andrews</u>	
<b>23d. LOCATION</b> (City, town or county) (State) <u>Maryd, Md</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thomas Houdy</u> ADDRESS <u>12 Ridgely Ave. Annapolis, Md</u>			
<b>25a. REC'D BY REGISTRAR</b> <u>JAN 13 1966</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Lee as judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

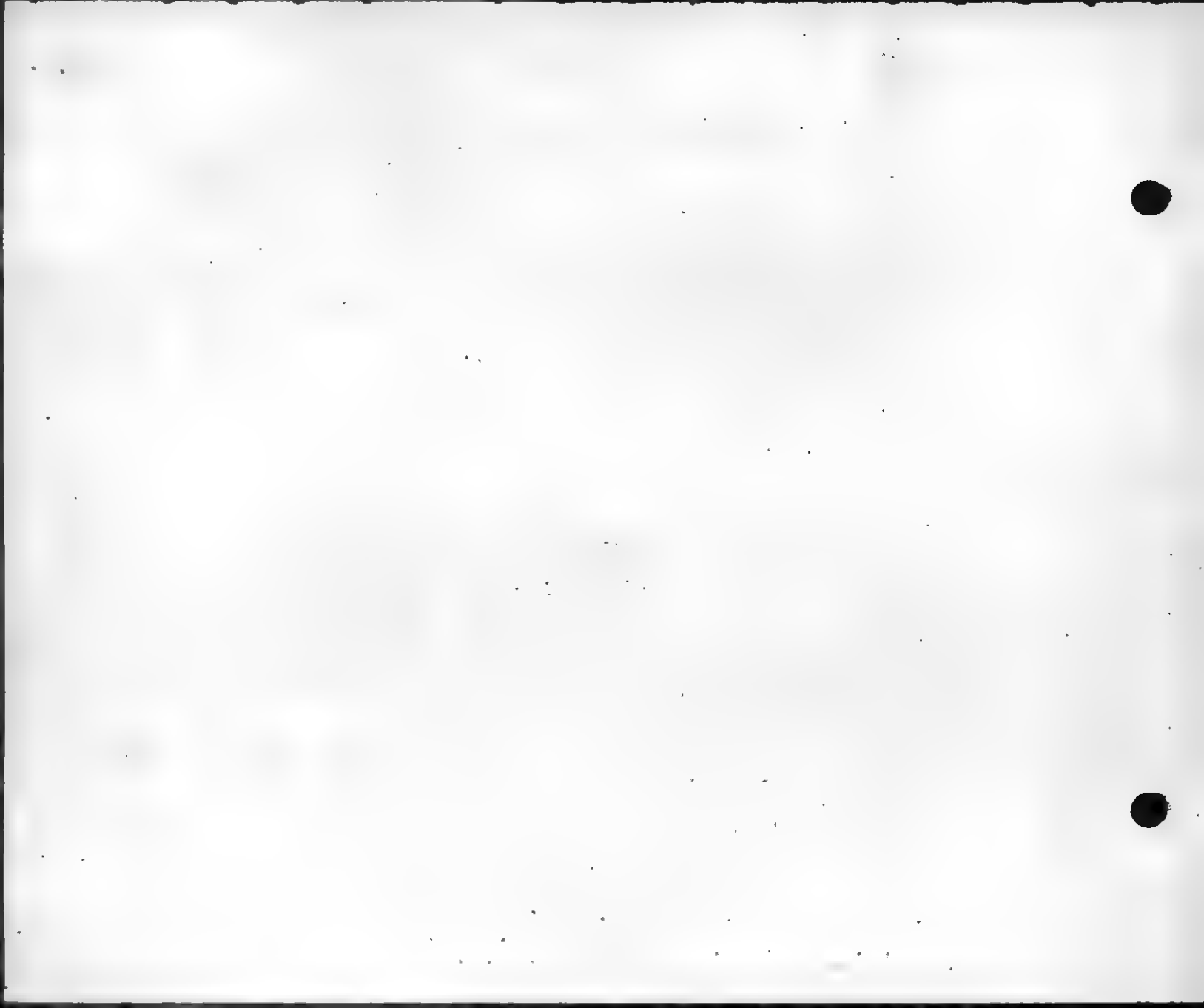


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b> c. LENGTH OF STAY IN b. <b>3 WEEKS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KNOLLWOOD MANOR NURSING HOME</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL, ANNAPOLIS</b> d. STREET ADDRESS <b>ROUTE 5, Box 217A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MIGNONETTE ELIZABETH BECKETT</b> 4. DATE OF DEATH <b>JANUARY 4 1966</b> 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>SEPT 22, 1870</b> 9. AGE (in years last birthday) <b>95</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>-</b> 11. BIRTHPLACE (County & State, or foreign country) <b>WAYNE CO. PENNSYLVANIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>											
13. FATHER'S NAME <b>EDGAR B. WELLS</b> 14. MOTHER'S MAIDEN NAME <b>MARIETTA BUCKINGHAM</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> 16. SOCIAL SECURITY NO. <b>-</b> 17. INFORMANT <b>Edgar W. Beckett - Same as #2</b> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> + x 00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>WEEKS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBRAL THROMBOSIS</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>DEC 16, 1965</b> to <b>DEC 23, 1965</b> , that (I) (we) last saw the deceased alive on <b>JAN 4, 1966</b> , and that death occurred at <b>7:00 A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Charles W. Kinzer</b> 22c. PHYSICIAN'S NAME (Type) <b>CHARLES W. KINZER, M.D.</b>						22b. DATE SIGNED <b>JAN 4, 1966</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>SOUTH RIVER MEDICAL CENT. EDGEMONT, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> 23b. DATE THEREOF <b>1/6/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Prince Georges County Md.</b>						24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b> 25a. REC'D BY REGISTRAR <b>JAN 7 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00093

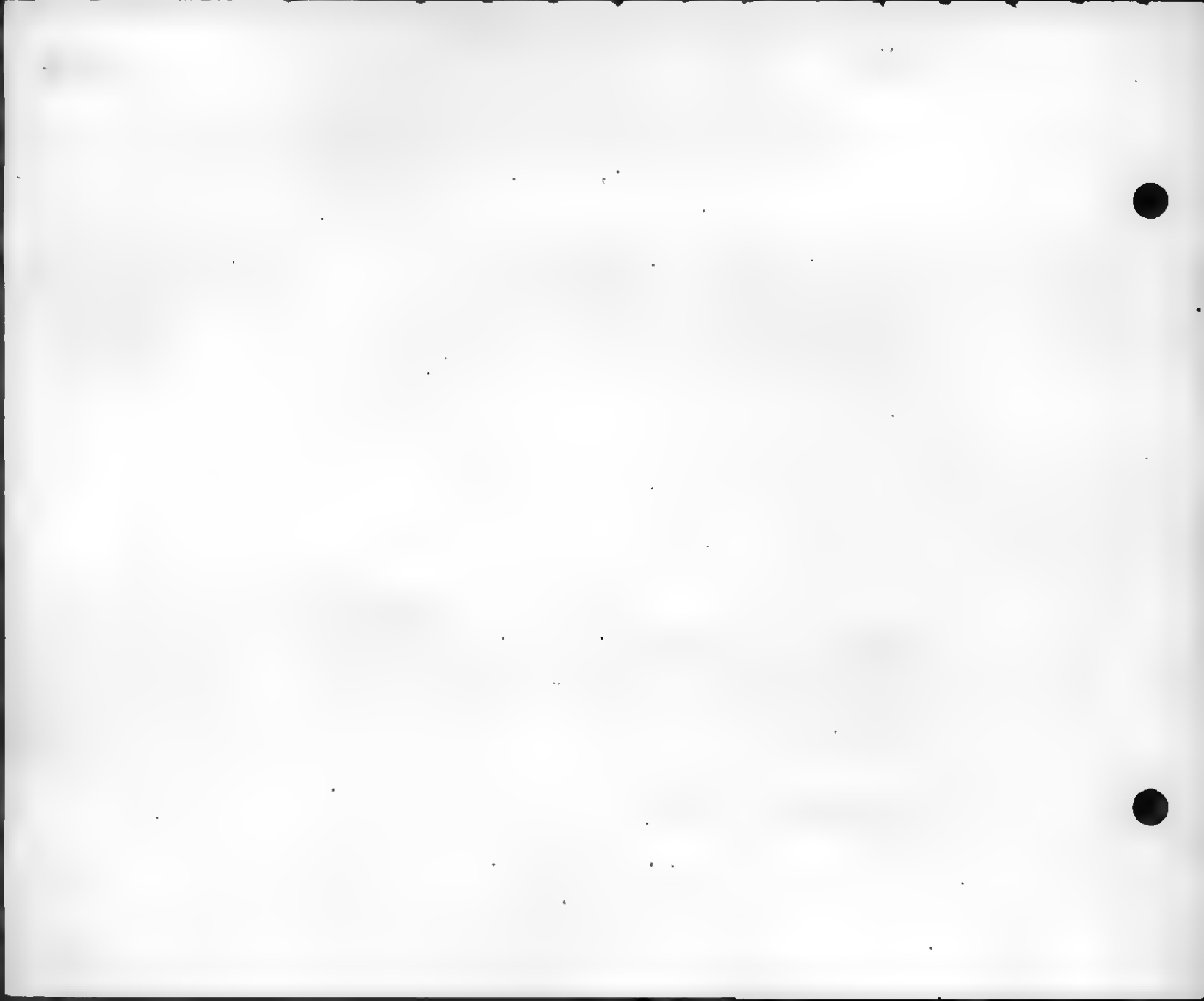
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00092

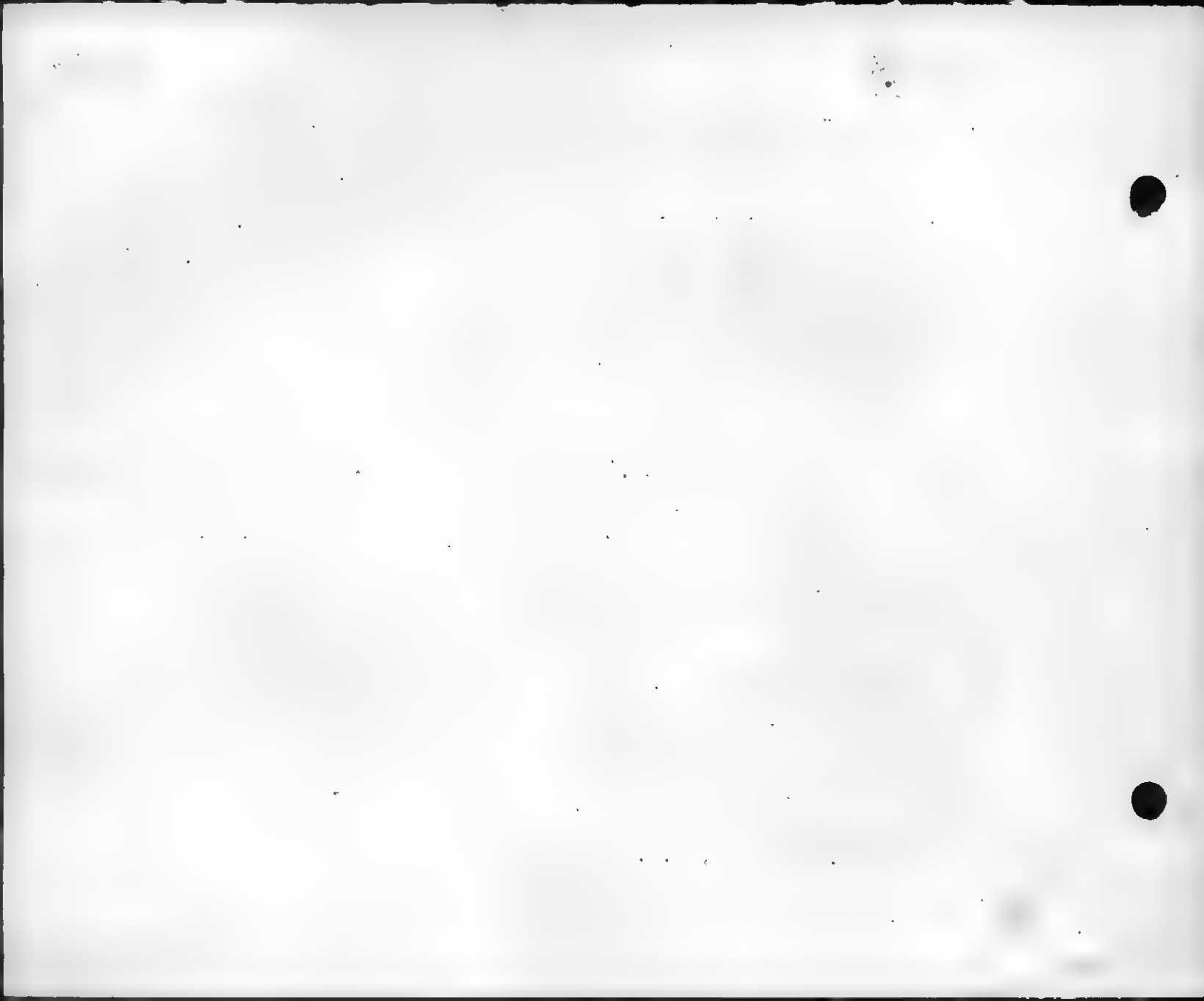
1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1d 3 Yrs. 3 mos.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS Brodwin Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #23500 Harry Lawrence Booth				4. DATE OF DEATH Month Jan. Day 5 Year 1966			
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/16/1894	9. AGE (in years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Maggie Booth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) General Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain Syndrome sec. to General Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year ----- 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 3/28/1962, to 1/5/1966, that (I) (we) last saw the deceased alive on 1/5/1966, and that death occurred at 9:20 M, from the causes and on the date stated above.							
22a. SIGNATURE Hildagarde H. Reissman				22b. DATE SIGNED 1/6/66		22c. PHYSICIAN'S NAME (Type) Hildagarde H. Reissman M.D.	
22d. ADDRESS Crownsville State Hospital				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-7-66		23c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR W. Reissman				25a. REC'D BY REGISTRAR AN 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>30-4</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		3. NAME OF DECEASED (Type or print) <u>Christine</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6/12/1912</u>		9. AGE (In years last birthday) <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lucillian Boswell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertension - Arteriosclerotic</u> DUE TO (c) <u>Vascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>-----</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>2:00</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	
20f. (City or town) (County) (State) <u>-----</u>		21. I certify that (I) (this hospital) attended the deceased from <u>6/23/1966</u> to <u>1/7/1966</u> , that (I) (we) last saw the deceased alive on <u>1/7/1966</u> , and that death occurred at <u>10:15</u> A.M. from the causes and on the date stated above.		22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/7/66</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>	
22d. ADDRESS <u>Crownsville State Hospital</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-10-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Albion Memorial Park Brookline</u>		23d. LOCATION (City, town or county) (State) <u>140</u>	
24. FUNERAL DIRECTOR <u>Elroy C. Nelson</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>JAN 10 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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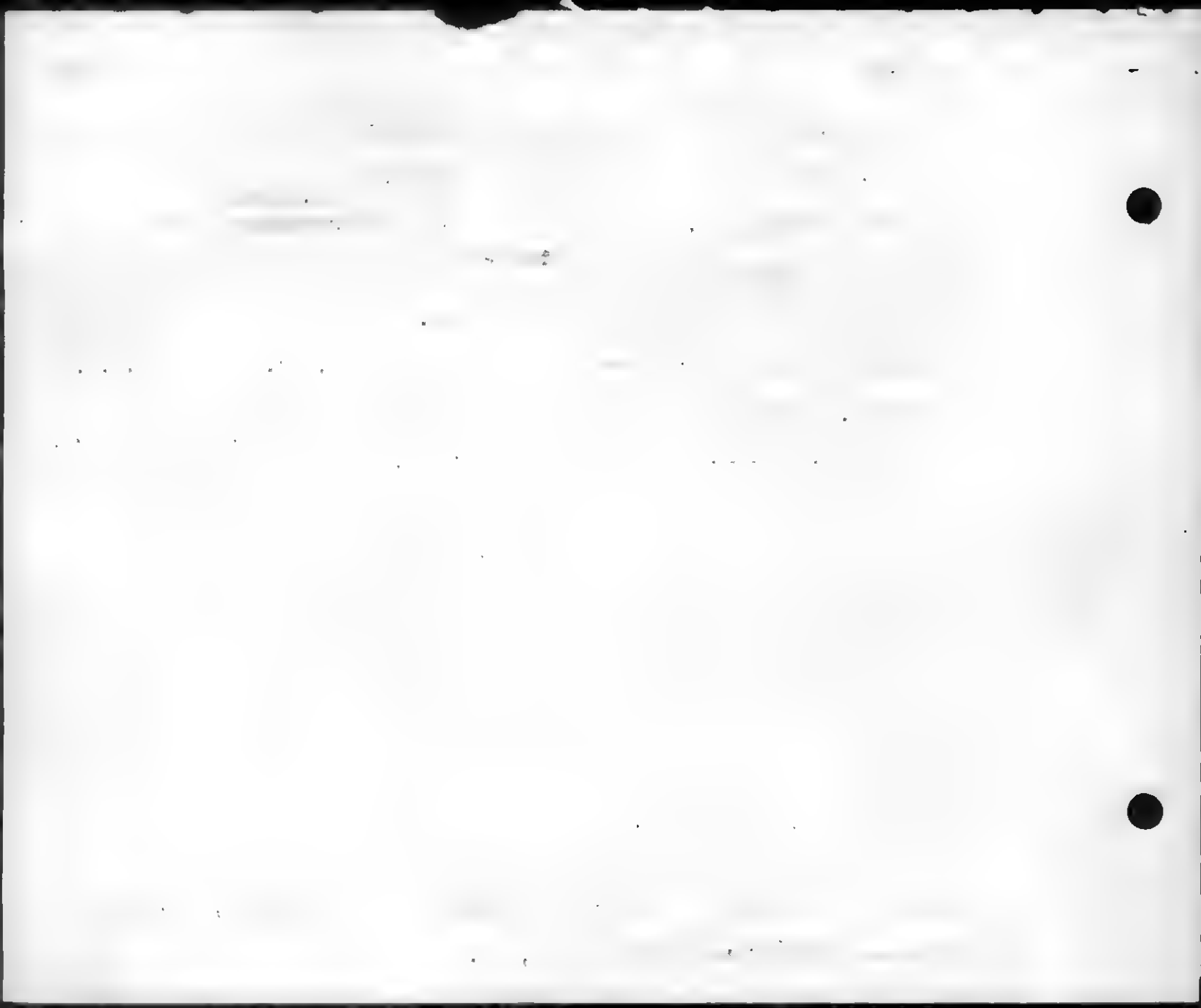
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00095

00094

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 10 <b>North Arundel Hosp.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>306 Fort Smallwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CAROLYN LORETTA BREIGNER</b>				4. DATE OF DEATH Month Day Year <b>January 6 19 66</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>31 Dec. 1926</b>	
9. AGE (in years last birthday) <b>39</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Glen Burnie, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry I. Knaus</b>				14. MOTHER'S MAIDEN NAME <b>Ernestine Kissar</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mildred I. Andretta (sister)</b> Address <b>102 Second Ave Glen Burnie</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> DUE TO (b) <b>severe Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-5</b> , 19 <b>66</b> , to <b>1-6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-6</b> , 19 <b>66</b> , and that death occurred at <b>5<sup>4</sup></b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Ernest A. Leipold</b>				22b. DATE SIGNED <b>Jan 6, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Ernest A. Leipold, M.D.</b>	
22d. ADDRESS <b>Arundel Med. Group, Glen Burnie, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Brooklyn, Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert R. Ware</b> Address <b>Singleton Road, Glen Burnie, Md.</b>				25a. REC'D BY REGISTRAR <b>Jan 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



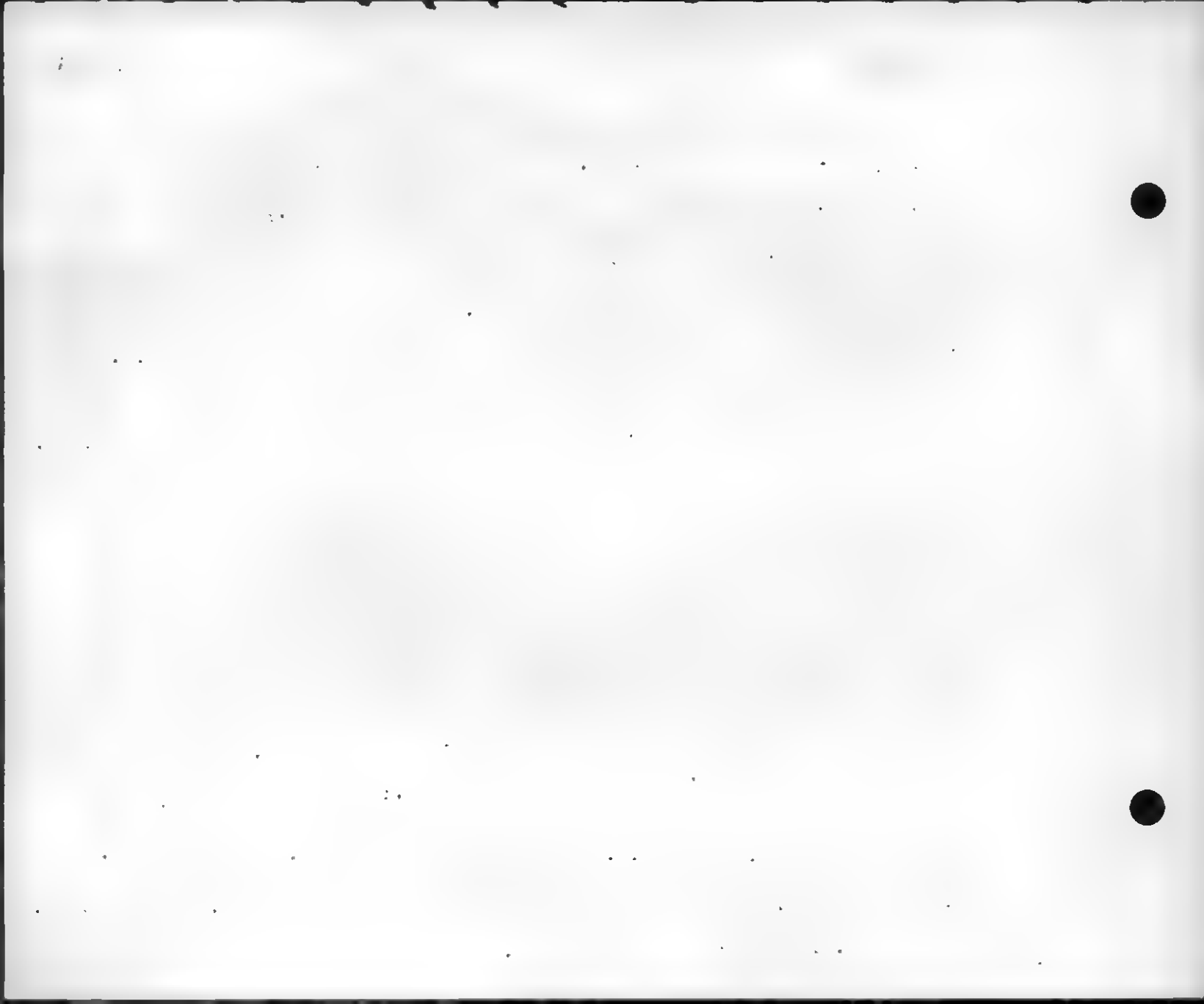


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be removed from the certificate, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN ID <b>Mins.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>111 Northwest St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Henrietta HILL BUMBRA</b> First Middle Last						4. DATE OF DEATH <b>January 11 1966</b> Month Day Year					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 30, 1879</b>		9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Charles Hill</b>						14. MOTHER'S MAIDEN NAME <b>Susan Boston</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-22-3373</b>		17. INFORMANT <b>Viola Jackson-111 Northwest Annapolis, Md.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis</b> DUE TO (b) <b>Arteriosclerosis hypertensive</b> DUE TO (c) <b>7-10420</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (If deceased) attended the deceased from <b>April 1960</b> , to <b>Jan. 11 1966</b> , that (I) last saw the deceased alive on <b>Jan. 11 1966</b> , and that death occurred at <b>1:40 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Faye W. Allen, M.D.</b>						22b. DATE SIGNED <b>1-12-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Faye W. Allen, M.D.</b>						22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 14-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Bestgate Rd. Annapolis, Md.</b>			
24. FUNERAL DIRECTOR <b>C.E. Hicks 111 Annapolis, Md.</b> ADDRESS						25a. REC'D BY REGISTRAR <b>Jan 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

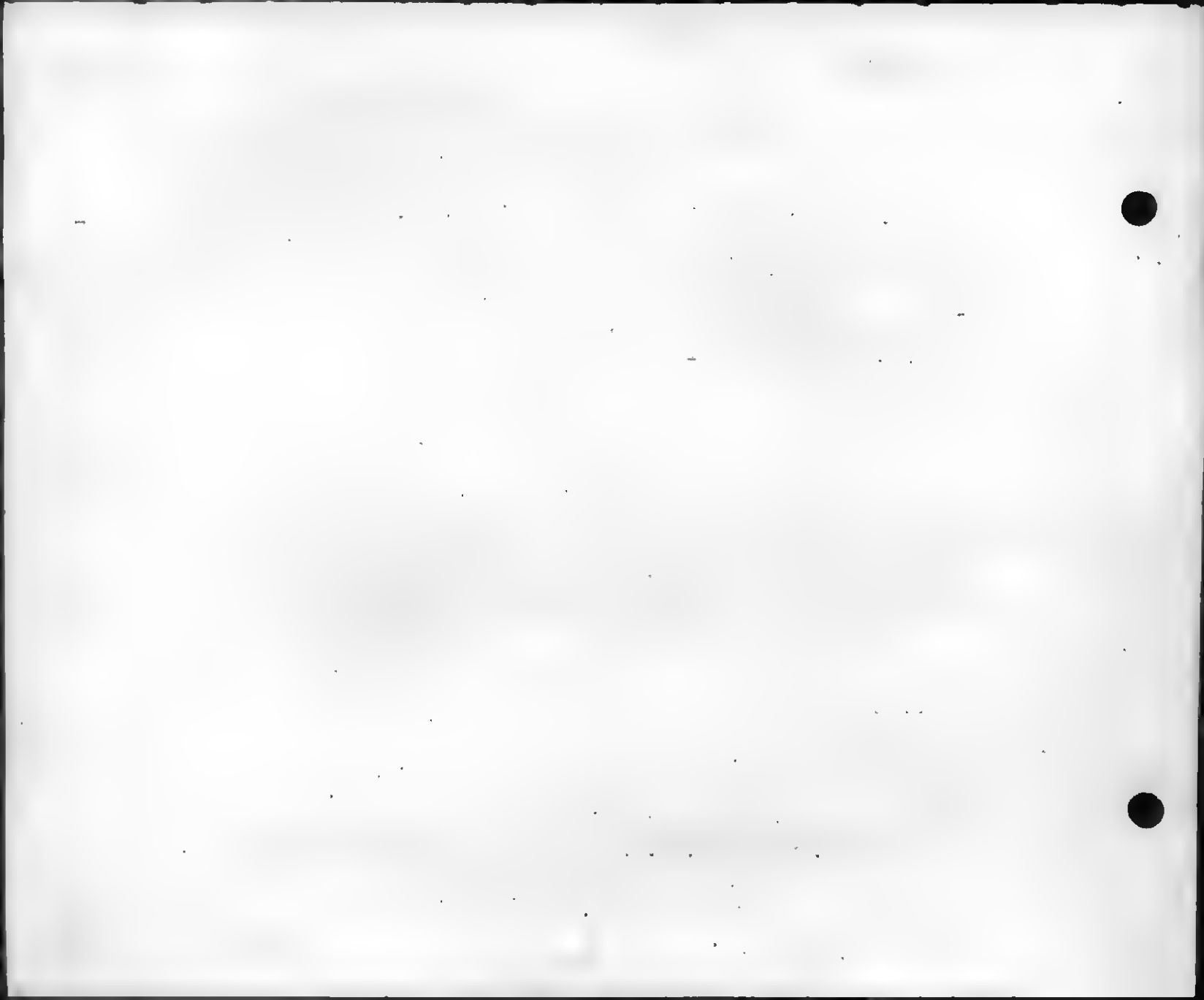
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CERTIFICATE OF DEATH

01640

Item #8 - 111m #11113 2/11/66 DC

1. PLACE OF DEATH a. COUNTY Anne Arundel County			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 6 years		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital			d. STREET ADDRESS 2101 N. Cold Spring Lane		
3. NAME OF DECEASED (Type or print) First Middle Last Effie Burgess			4. DATE OF DEATH Month Day Year 1 30 1966		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		8. DATE OF BIRTH 2/10/19 93	
11. BIRTHPLACE (County & State, or foreign country) Unknown		9. AGE (in years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Oliver Jerrells		14. MOTHER'S MAIDEN NAME Mary Madden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO (b) Status Epilepticus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Traumatic Epilepsy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH? ? minutes 7 minutes 6 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Room A.M. P.M. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12/4/1959 to 1/30/1966, that (I) (we) last saw the deceased alive on 1/30/1966, and that death occurred at 11:40 P.M. from the causes and on the date stated above.					
22a. SIGNATURE L. Benedict, M.D.				22b. DATE SIGNED FEB 8 1966	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/16/66		23c. NAME OF CEMETERY OR CREMATORY McCrory Cem	
23d. LOCATION (City, town or county) aa County Md		24. FUNERAL DIRECTOR Milton E. Clarkson 1129 N. Caroline St			
25a. REC'D BY REGISTRAR FEB 8 1966		25b. REGISTRAR'S SIGNATURE James J. J...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00098

## CERTIFICATE OF DEATH

00096

1. PLACE OF DEATH a. COUNTY <b>ANNA ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT G G MEADE</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchelville</b> d. STREET ADDRESS <b>10 Park Drive Sherwood Manor</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>18</b> Year <b>19 66</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 16, 66</b>	9. AGE (in years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Na</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anna Arundel, Md</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Larry S Byrum</b>					
14. MOTHER'S MAIDEN NAME <b>Elizabeth Diane Cooper</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>					
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Father</b>		Address <b>Same As Item # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apneic Episode</b> DUE TO (b) <b>Prematurity</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>Life</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 16, 1966</b> to <b>Jan 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>18 Jan 19 66</b> , and that death occurred at <b>11:01 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Fred M Nomura</b>		22b. DATE SIGNED <b>18 Jan 66</b>		22c. PHYSICIAN'S NAME (Type) <b>FRED M NOMURA, CAPT, MC</b>			
22d. ADDRESS <b>HQ KIMBROUGH AH FT G G MEADE, MD 20755</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Jan. 20, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>		23d. LOCATION (city, town or county) (State) <b>ARLINGTON, VIRGINIA</b>			
24. FUNERAL DIRECTOR <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>		25a. REC'D BY REGISTRAR <b>IAN 24 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Jones</b>			



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1

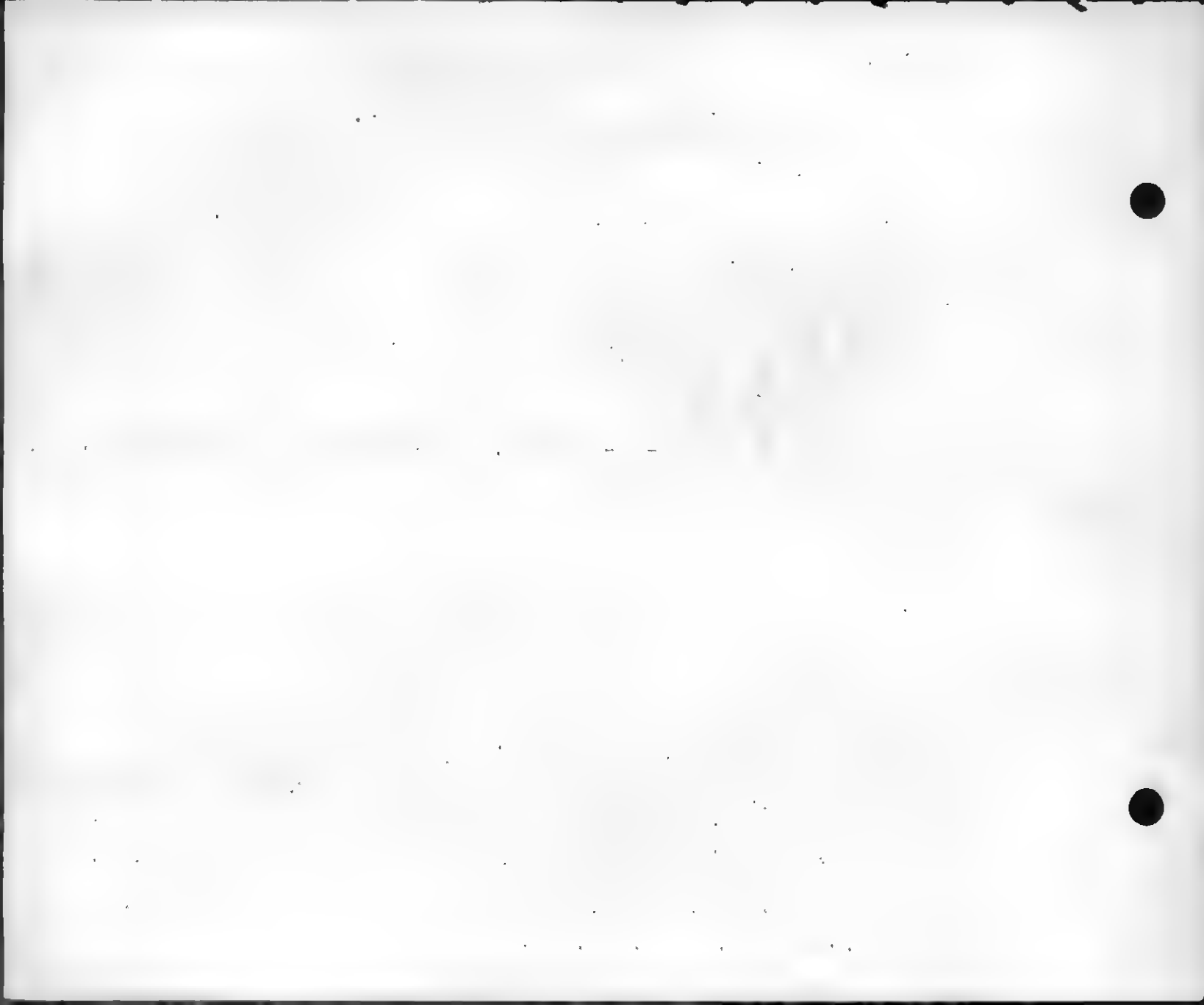
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00099 CERTIFICATE OF DEATH 00097									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					d. STREET ADDRESS <u>5401 Catalpha Rd.</u>				
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Margaret Leper CHENOWETH</u>					4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1877</u>		9. AGE (In years last birthday) <u>88</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME <u>Ludwig Lepper</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>218-12-3068</u>		17. INFORMANT <u>Mr. George Chenoweth</u>		
					Address <u>2345 Hartford Rd.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 351X OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ OUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> , 19 <u>66</u> , to <u>1/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/14</u> , 19 <u>66</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/15/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman M. D.</u>					22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/17/66.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>					25a. REC'D BY REGISTRAR DATE <u>1/20/66</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00100

00098

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundle</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hanover</u> c. LENGTH OF STAY IN b. <u>48 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt #2 Box 20 Hanover Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundle</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hanover</u> d. STREET ADDRESS <u>Race Road Rt. #2 Box 20</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mabel</u> <u>Idell</u> <u>Cook</u>				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>5,</u> Year <u>1966</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/17/1889</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Laurel Princee Geo, Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>			
<b>13. FATHER'S NAME</b> <u>Thomas K. Simms</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mamie E. Dublin</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Mr. Frank Hebron</u> <u>Hanover, Md</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular</u> <u>1431</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Hanover</u>		<b>(County)</b> <u>Anne Arundle</u>		<b>(State)</b> <u>Md</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 1 1965</u> <b>to</b> <u>Jan 5 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 5 1965</u> <b>and that death occurred at</b> <u>11 P.M.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Frank E. Shipley</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Jan 12 1966</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Frank E. Shipley</u>				<b>22d. ADDRESS</b> <u>Savage, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/9/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Rest Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Harmans</u>		<b>(State)</b> <u>Md</u>			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Herbert E. Nutter</u>				<b>ADDRESS</b> <u>3035 W. North Ave</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Jan 12 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Williamas Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

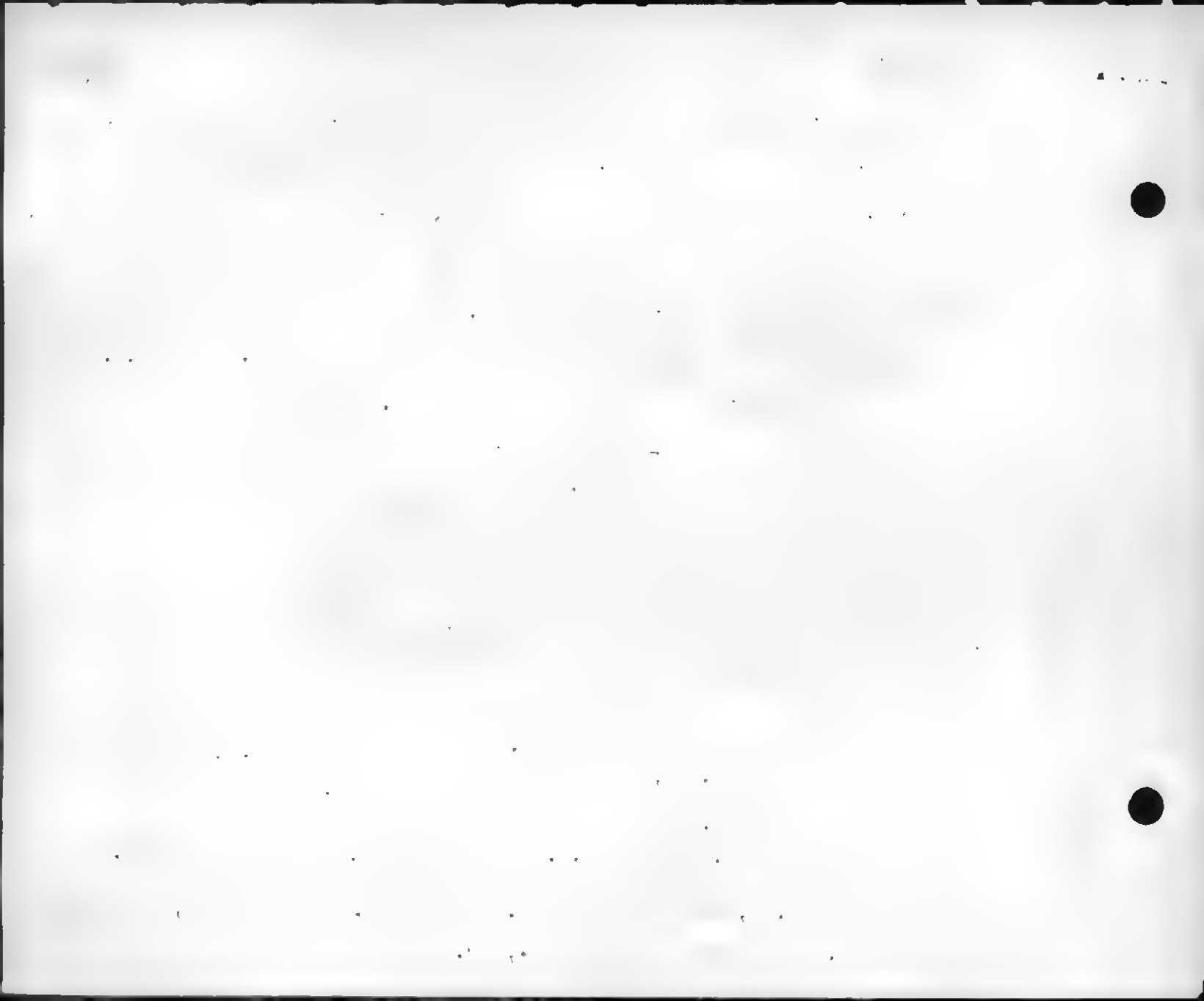
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00099

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN ID <b>8 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL- Crownsville 21032</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt-2, Box-358</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leona</b>		First <b>(none)</b> Middle <b>(none)</b> Last <b>COX</b>		4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1889</b>	9. AGE (in years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland (Balto.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Fred Steiner</b>				14. MOTHER'S MAIDEN NAME <b>K. Emerine</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-6430</b>		17. INFORMANT (Daughter) <b>Mrs Genevieve Ferrier</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH. <b>6-8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chromidiosis blood disease</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>May</b> , 19 <b>62</b> to <b>Jan. 12</b> , 19 <b>66</b> , that (I) <b>had</b> last saw the deceased alive on <b>Jan. 12</b> , 19 <b>66</b> , and that death occurred at <b>8:20 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/13/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>				22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baldwin Mem. Church Cem. Millersville, Maryland</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b>		ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>Jan 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. W. Judge</b>	

MEDICAL CERTIFICATION



00192

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Page 4 may be retained by the hospital at attending physician's request.

→ **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

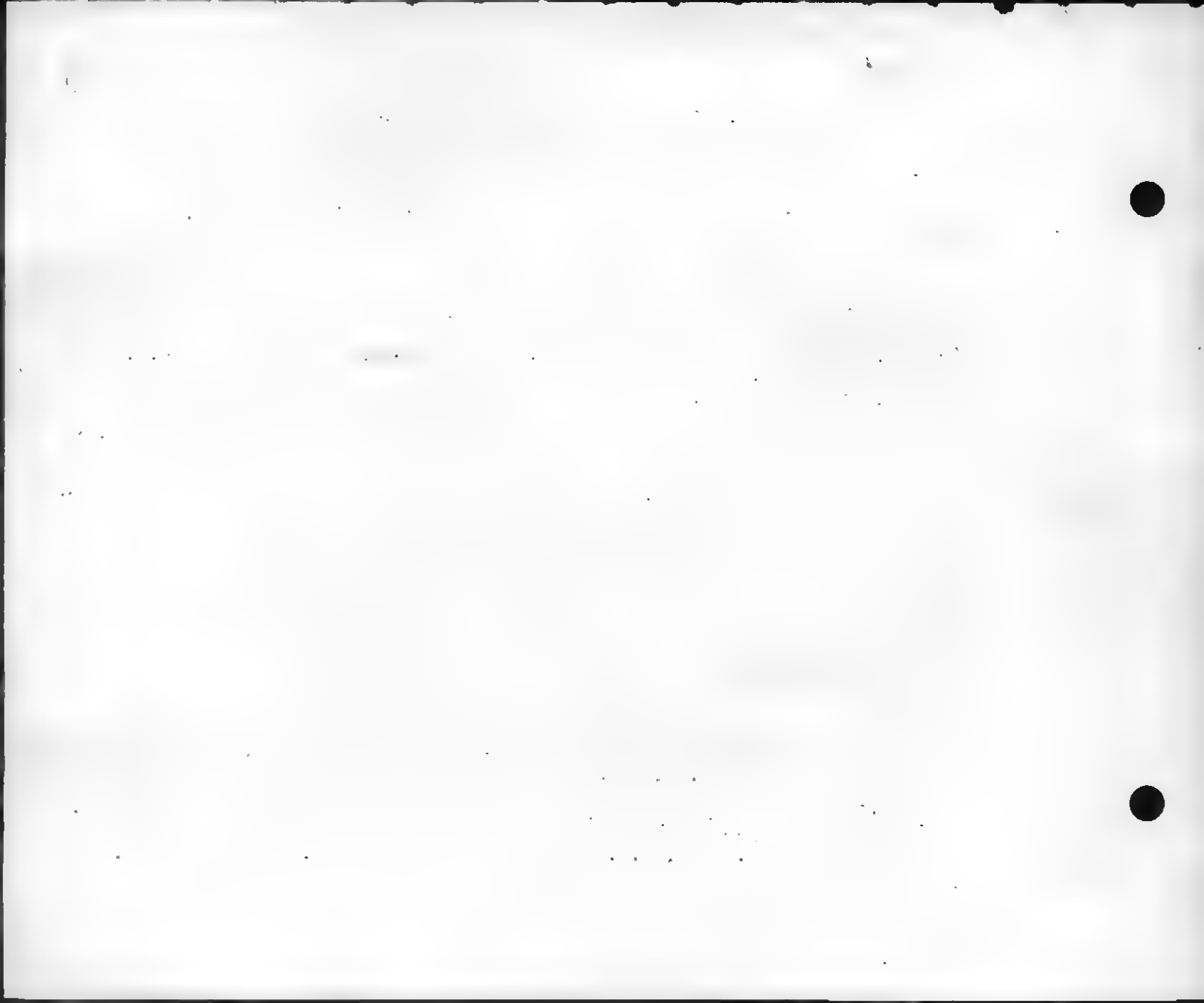


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>104 Duke of Gloucester St.,</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Joseph CROWLEY</u>		4. DATE OF DEATH Month Day Year <u>1 6 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1887</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>1 6 19 66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. BAILIFF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. A. CO. COURT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE J. CROWLEY</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES MARRON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWI</u>		16. SOCIAL SECURITY NO. <u>MRS. ISABELLA CROWLEY #2</u>	
17. INFORMANT <u>MRS. ISABELLA CROWLEY #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 42-1 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1/6</u> , 19 <u>66</u> , to <u>Jan. 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED <u>1-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck, M.D.</u>		22d. ADDRESS <u>73 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-10-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR, SR.</u>		25a. REC'D BY REGISTRAR <u>1 JAN 11 1966</u>	
ADDRESS <u>ANNAPOLIS MD.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>A.A. Co</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Eastport</i>		c. LENGTH OF STAY IN 1b <i>12/17/66</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Edgewater Md.</i>		b. COUNTY <i>Md.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Edgewater Md.</i>	
3. NAME OF DECEASED (Type or print) First <i>Isabella</i> Middle <i>Cummings</i> Last <i>Cummings</i>						4. DATE OF DEATH Month <i>July</i> Day <i>18</i> Year <i>1884</i>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 18, 1884</i>		9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>18</i> Hours <i>18</i> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>A.A. Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>Yes</i>			
13. FATHER'S NAME <i>Samuel Asher</i>				14. MOTHER'S MAIDEN NAME <i>Crandell, Mary Katherine</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Merle Cummings</i>				Address <i>Mayo Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Heart Disease</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10/11</i> , 19 <i>65</i> , to <i>1/17</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/16</i> , 19 <i>66</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Edward J. Beck</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>1/17/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Edward J. Beck</i>				22d. ADDRESS <i>71 Franklin St, Annapolis, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 9 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mayo Memorial</i>		23d. LOCATION (City, town or county) (State) <i>Mayo Md.</i>					
24. FUNERAL DIRECTOR <i>Hardesty Funeral Home Ltd. Lesville Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>JAN 17 '66</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

Two-for-one Film G372 1/14/66 mh

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# MARYLAND STATE DEPARTMENT OF HEALTH

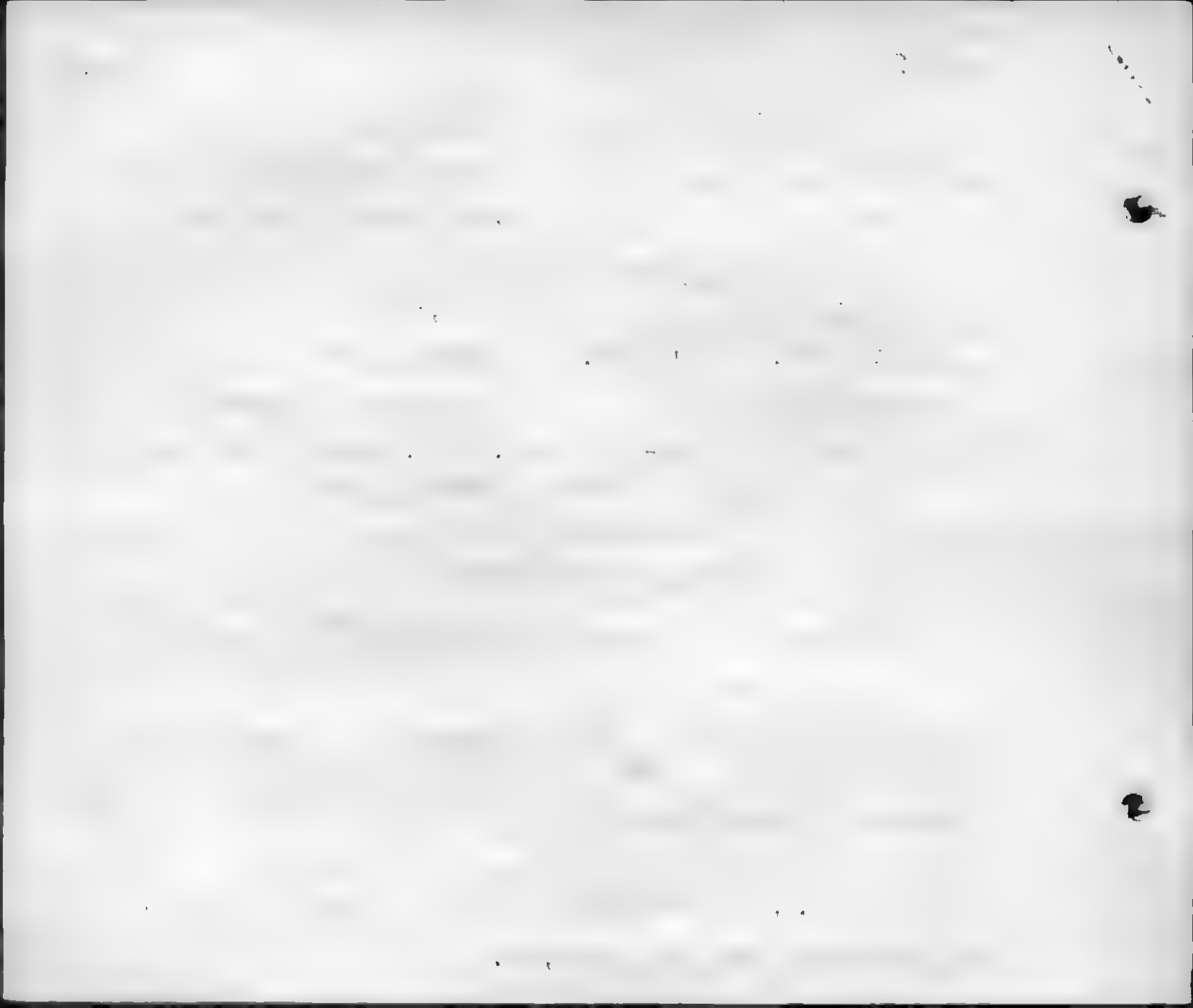
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00105

01655

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN TB <u>///////</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Brookfield on the Magothy)</u> d. STREET ADDRESS <u>Rt. # 4 Box #88 (Ridge Road)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Daniels</u>		4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7th, 1889</u> <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist (ret.)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Richard Daniels</u>		14. MOTHER'S MAIDEN NAME <u>Eulalie Maddox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-18-5330</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Atherosclerotic Cerebral Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>Carcinoma of Urinary Bladder 1965</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>66</u> , to <u>1/31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward P. Kallene</u>		22b. DATE SIGNED <u>2/1/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Eugene B. Flinn</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>	
ADDRESS <u>Singleton Funeral Home Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00106 01658											
1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY /					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenville				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 402 W. Pratt St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greenville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) 31090 First Paul Middle Lester Last Davis						4. DATE OF DEATH Month 1 Day 16 Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/26/04		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer Davis						14. MOTHER'S MAIDEN NAME Mary Davis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes give war or dates of service) Unknown		17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) General Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1966-1-13-19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/13/1966, to 1/16/1966, that (I) (we) last saw the deceased alive on 1/15/1966, and that death occurred at 3 P.M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) L. Beaudict, M. D.						22d. ADDRESS 25d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/10/66		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl.		23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR William Reese, Jr. - Anna Md.						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge					
DATE FEB 8 1966											

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

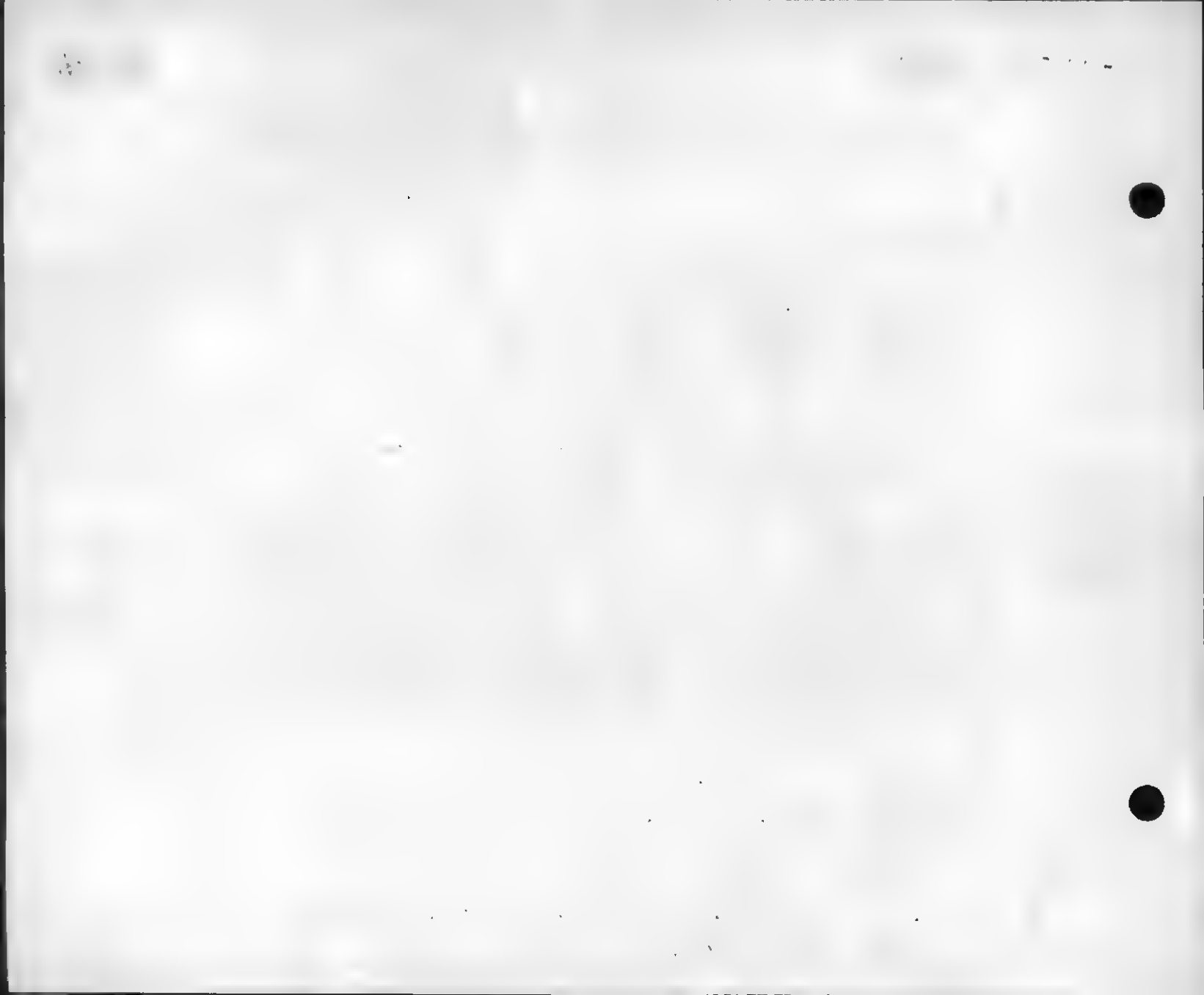
00107

## CERTIFICATE OF DEATH

00103

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>25 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, Md.</u> d. STREET ADDRESS <u>Mountain Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Melora Ray Della</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>2</u> Year <u>1966</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>September 13, 1914</u>		<b>9. AGE</b> (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>electrician</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Marion Chemical</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>											
<b>13. FATHER'S NAME</b> <u>Charles E. Della</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Cheney</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>215-078348</u>				<b>17. INFORMANT</b> Address <u>Mrs. Rosalea Della Same</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> DUE TO (b) <u>Carcinoma of the left axillary area</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,												INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>5 months</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>none</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 1, 1956</u> , to <u>January 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 1, 1966</u> , and that death occurred at <u>12 PM</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>R.M. McLaughlin</u>								<b>22b. DATE SIGNED</b> <u>1/2/66</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R.M. McLaughlin</u>								<b>22d. ADDRESS</b> <u>Pasadena, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>5 Jan 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Memorial</u>				<b>23d. LOCATION (City, town or county)</b> (State) <u>Glen Burnie Md.</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Longlton Funeral Home</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Jan 5 1966</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>James W. J. J.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00108

## CERTIFICATE OF DEATH

00104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RIVA</u> c. LENGTH OF STAY IN lb <u>RIVA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RIVA ROAD</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RIVA</u> d. STREET ADDRESS <u>RIVA RD.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>NELLIE</u> <span style="float: right;">First Middle Last</span> <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>NOV 30 1891</u> <b>9. AGE</b> (In years last birthday) <u>74</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RET.</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>KANSAS</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>CYRUS KING</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>UNKN.</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>—</u> <b>17. INFORMANT</b> <u>JOHN J. DIGNAN</u> Address <u>#2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Serious Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis heart disease</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>1965</u> Hour a.m. <u>6/6</u> p.m. <u>1/4</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>121 CATHARINE ST ANNAPOLIS</u> <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>6/6</u> 19 <u>65</u> to <u>1/4</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/4/66</u> 19 <u>66</u> , and that death occurred at <u>6</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>General Church</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>GERMAN CHURCH</u>		<b>22b. ADDRESS</b> <u>121 CATHARINE ST ANNAPOLIS</u>		<b>22d. DATE SIGNED</b> <u>1/5/66</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>1-7-66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FT. LINCOLN</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>BLADENSBURG MD.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Lyons</u> <b>ADDRESS</b> <u>Annapolis, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 6 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

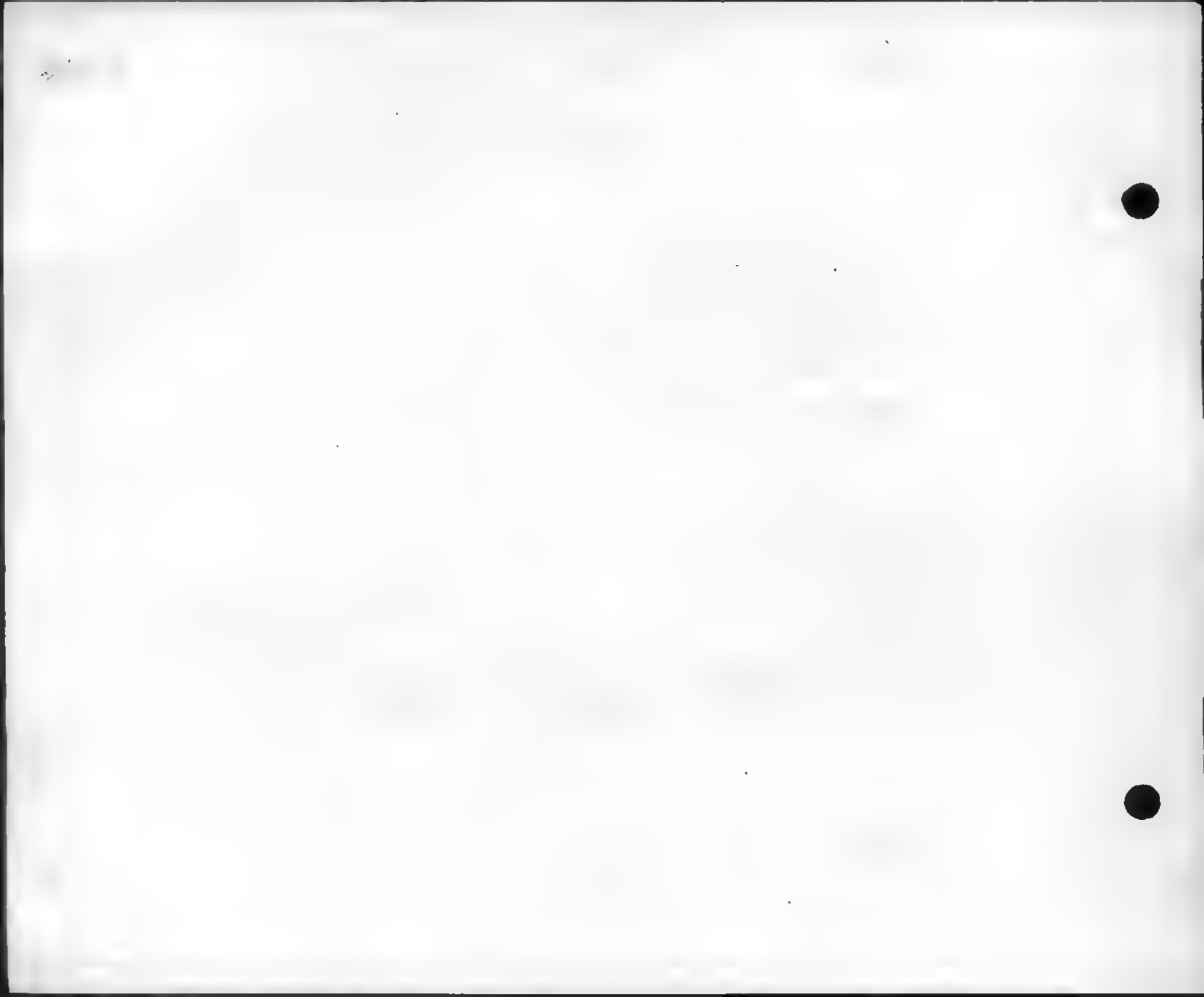


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00109						00105					
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Junction</i>				c. LENGTH OF STAY IN 1b <i>13 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Junction</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rt 32</i>						d. STREET ADDRESS <i>Rt 32</i>					
3. NAME OF DECEASED (Type or print) <i>SARAH ELIZABETH DISNEY</i>						4. DATE OF DEATH Month <i>1</i> Day <i>12</i> Year <i>1966</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/26/78</i>		9. AGE (In years last birthday) <i>87 yrs.</i>		IF FUNER 1 YEAR Months <i>1</i> Yrs <i>1</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Sevier Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>George Watts</i>						14. MOTHER'S MAIDEN NAME <i>Killian Jacobs</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Shirley McLean Laurel</i> Address <i>Harding Rd Laurel Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHOPNEUMONIA</i> DUE TO (b) <i>A.S.C.V.D. WITH HYPERTENSION</i> DUE TO (c) <i>Gen'l Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>15 yrs</i> <i>18 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>11/25/1957</i> , 1957, to <i>1/12/1966</i> , 1966, that (I) (we) last saw the deceased alive on <i>1/11/1966</i> , and that death occurred at <i>4:55 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>J.M. Warren</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/12/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>J.M. Warren</i>						22d. ADDRESS <i>Laurel Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-15-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Rt George Meade Md</i>					
24. FUNERAL DIRECTOR <i>Shirley McLean Laurel Md</i>						25a. REC'D BY REGISTRAR <i>19 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Johnas Judge</i>			



1  
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00110

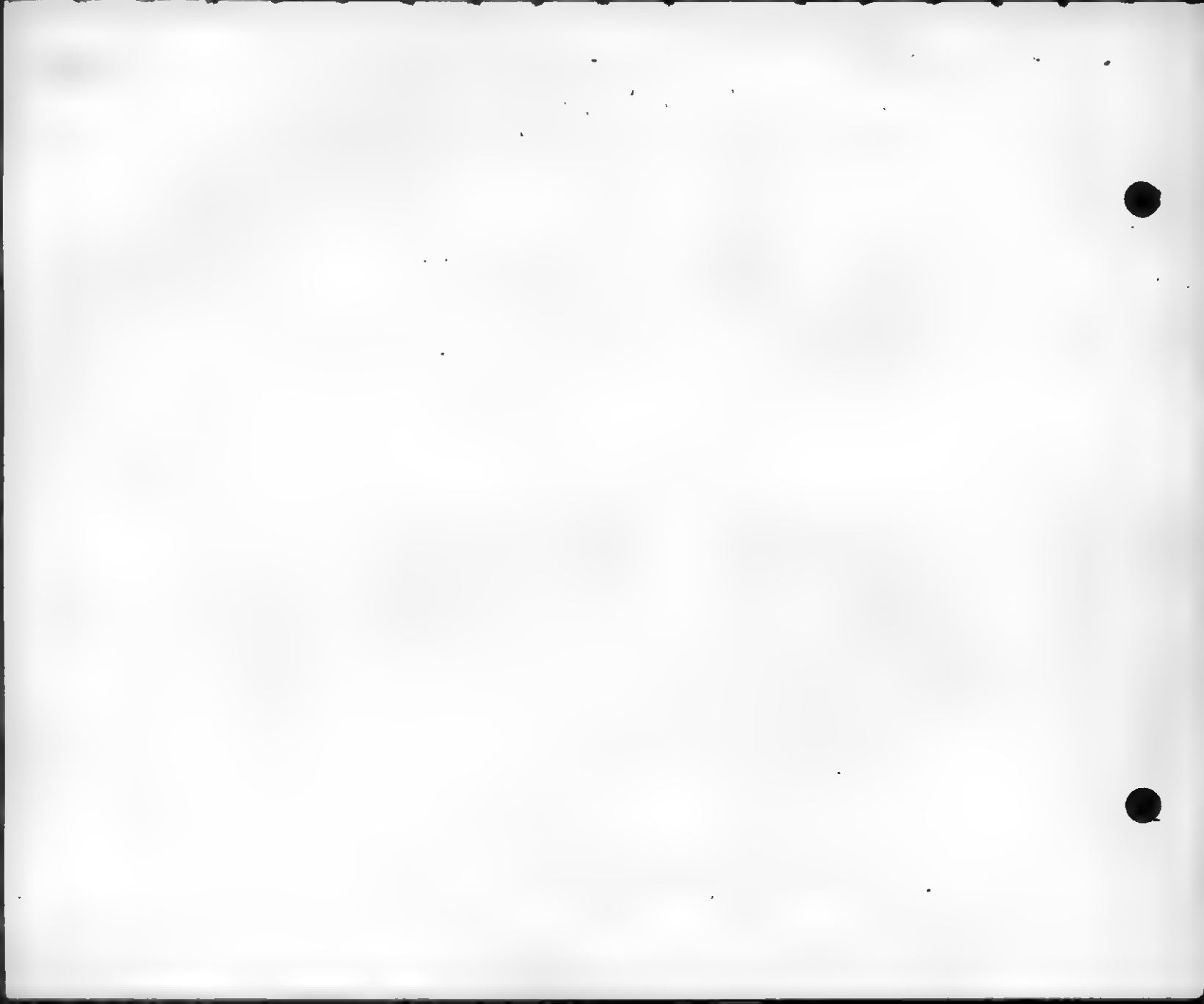
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00106

1. PLACE OF DEATH a. COUNTY <i>HA Co</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA Co</i> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>Maryland</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>D.O.A. - Anne Arundel I. Gen.</i>				d. STREET ADDRESS <i>Bristol</i>			
3. NAME OF DECEASED (Type or print) First <i>Patrick</i> Middle <i>V.</i> Last <i>Dorsey</i>				4. DATE OF DEATH Month <i>1</i> Day <i>8</i> Year <i>1966</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-22-65</i>		9. AGE (In years last birthday) <i>1</i> yrs. <i>5</i> months <i>2</i> days <i>19</i> min.	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Maryland Frederick Hosp. Wash, D.C.</i>	
13. FATHER'S NAME <i>James Dorsey</i>				14. MOTHER'S MAIDEN NAME <i>Edith Blake</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Dorsey</i>		Address <i>Bristol - Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>+93X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <i>1-8-66</i> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <i>3:17</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>E.L. Howard</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>1-8-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>E.L. Howard</i>				22d. ADDRESS <i>Annapolis Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>1-10-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Way - Cross</i>		23d. LOCATION (City, town or county) (State) <i>Huntingtown - Calvert M</i>	
24. FUNERAL DIRECTOR <i>P.E. Sewell</i>				ADDRESS <i>Prince Fred, Maryland</i>		25a. REC'D BY REGISTRAR <i>JAN 14 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



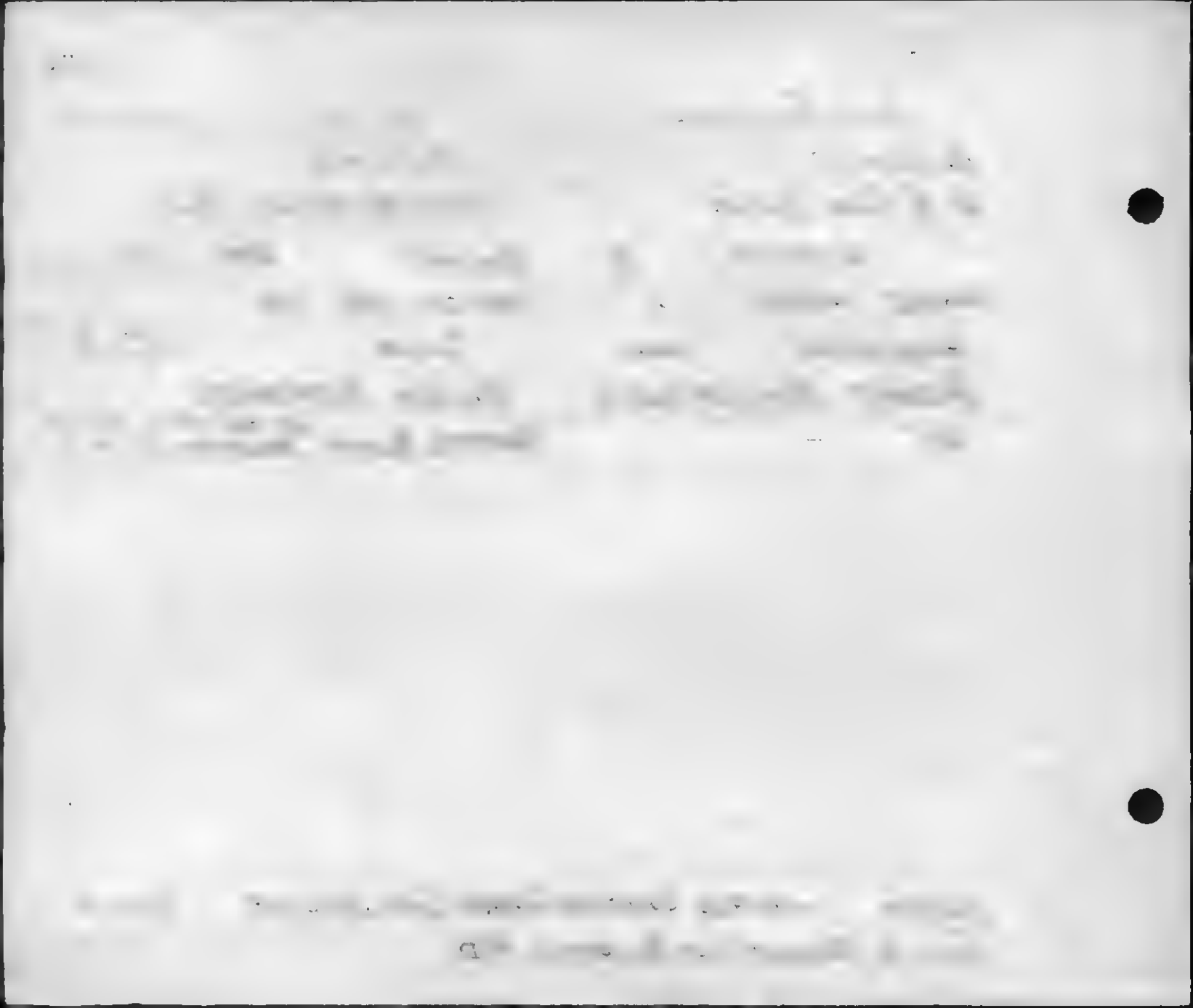
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VR A15 (4)  
 20M 5-63

1  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

00111		00107	
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A. A. GEN. HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>SHAWNEE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOPEKA</u> d. STREET ADDRESS <u>1517 MEDFORD AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WINNIE B. DUDLEY</u> First Middle Last 4. DATE OF DEATH <u>JAN 23 1966</u> Month Day Year		5. SEX <u>FEMALE</u> 6. CO. OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT 29 - 1891</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT HOLLENBECK</u>		14. MOTHER'S MAIDEN NAME <u>FLORA EDWARDS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>ROBERT L. DUDLEY 29 BRISTOL DRIVE ANNAPOLIS MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis Right Middle Cerebral artery</u> DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diverticulosis of sigmoid colon</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 29, 1965</u> to <u>Jan. 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1966</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>John L. Hedeman, MD</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN L. HEDEMAN</u>		22b. DATE SIGNED <u>1/24/66</u> 22d. ADDRESS <u>1407 FOREST DRIVE ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-28-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CHRISTIAN CHURCH CEM. EX LINE</u>		23d. LOCATION (City, town or county) (State) <u>IOWA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SONS ANNAPOLIS MD</u> ADDRESS <u>ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>JAN 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00112

## CERTIFICATE OF DEATH

00108

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>ANNAPOLIS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>N.Y. City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW YORK</u> d. STREET ADDRESS <u>5th AVE HOTEL 5th + 9th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>HARRY</u> First <u>EDWARDS</u> Middle Last <b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>1</u> Year <u>1966</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-5-1880</u> <b>9. AGE</b> (In years last birthday) <u>85</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ATTORNEY at LAW</u> <u>LAW</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>LAW</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>N.Y. City</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>SOLOMAN EDWARDS</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>SARAH "LUCY"</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> <input type="checkbox"/> <b>17. INFORMANT</b> <u>RICHARD I EDWARDS</u> Address <u>3528 S. RIVER TER. EDGEWATER, MD.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancerous Polyp</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>12</u> a.m. <u>12</u> p.m. 19 <u>66</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/65</u> <b>19</b> <u>11/1</u> <b>1966</b> <b>that (I) (we) last saw the deceased alive on</b> <u>12/21/1966</u> <b>and that death occurred at</b> <u>A</u> <b>M.</b> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>E. Linhardt</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>E. Linhardt</u> <b>22d. ADDRESS</b> <u>Chesapeake Maryland</u> <b>22e. DATE SIGNED</b> <u>1/1/66</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>CREMATION</u> <b>23b. DATE THEREOF</b> <u>1-2-1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FT. LINCOLN</u> <b>23d. LOCATION (City, town or county)</b> <u>BLADENSBURG</u> (State) <u>MD.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. G. ...</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 5 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00113

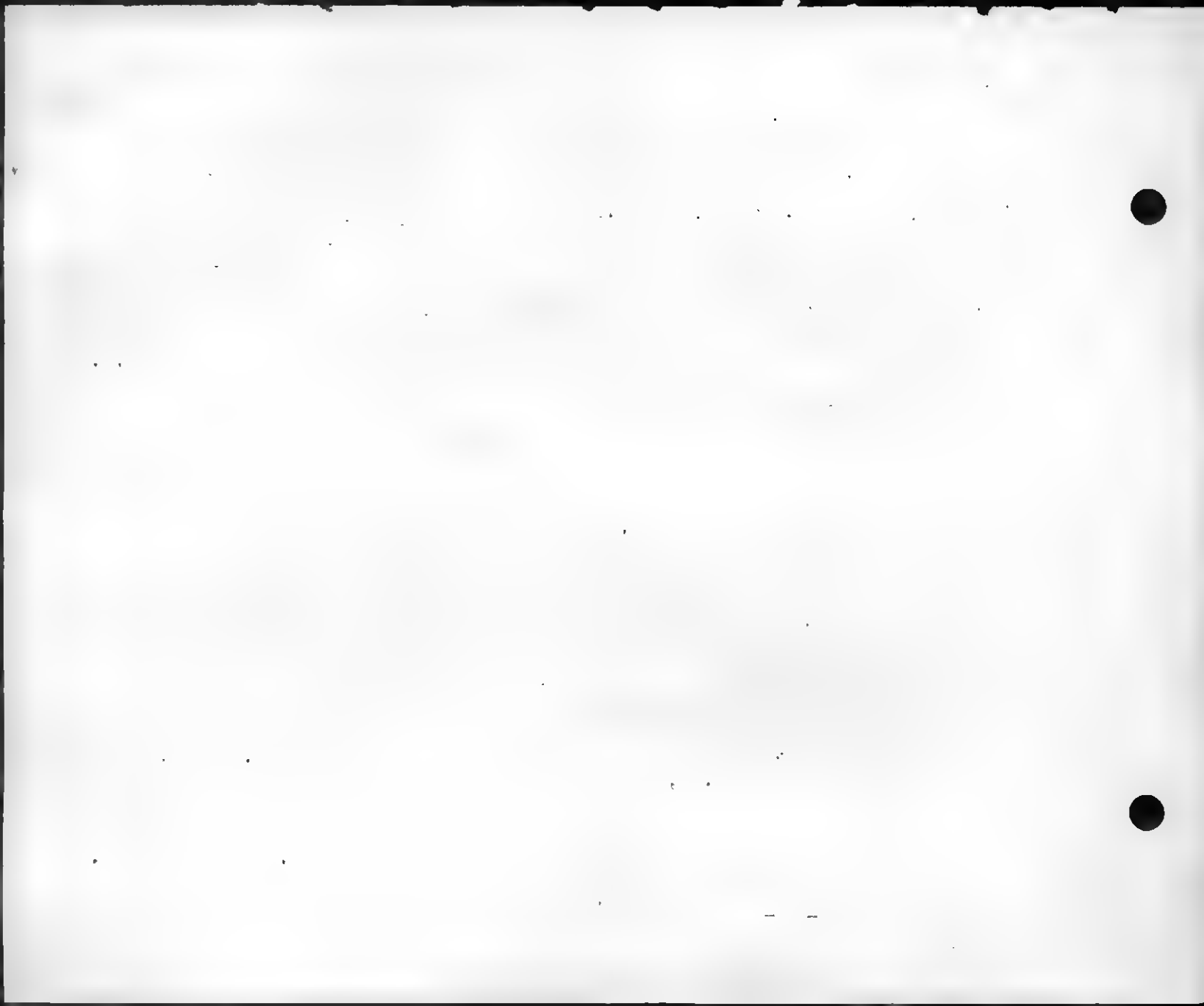
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

# 00109

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN ID <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - Glen Burnie</b> d. STREET ADDRESS <b>Rt-1, Box-284</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Samuel</b> First <b>Otis</b> Middle <b>EDWARDS</b> Last		4. DATE OF DEATH <b>January</b> Month <b>7</b> Day <b>1966</b> Year		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1900</b>		9. AGE (In years last birthday) <b>65</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>GEORGE EDWARDS</b>						14. MOTHER'S MAIDEN NAME <b>SARAH PITTS</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHARLOTTIE EDWARDS</b> Address <b>RT-1, Box 284</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Hypertension and renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis</b>												INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Yes</b> <b>Yes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) <b>Isaiah L. Brown</b> attended the deceased from <b>Jan. 1</b> , 1966, to <b>Jan. 7</b> , 1966, that (I) <b>last</b> saw the deceased alive on <b>Jan. 7</b> , 1966, and that death occurred at <b>11:00</b> M, from the causes and on the date stated above.													
22a. SIGNATURE <b>General Brown</b>												22b. DATE SIGNED <b>1/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>General Brown</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-12-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hell's Church Yard</b>		23d. LOCATION (City, town or county) (State) <b>A.A.CO., MD</b>					
24. FUNERAL DIRECTOR <b>Isaiah L. Brown &amp; Son</b>				ADDRESS <b>108 W. Montgomery St</b>		25a. REC'D BY REGISTRAR <b>JAN 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

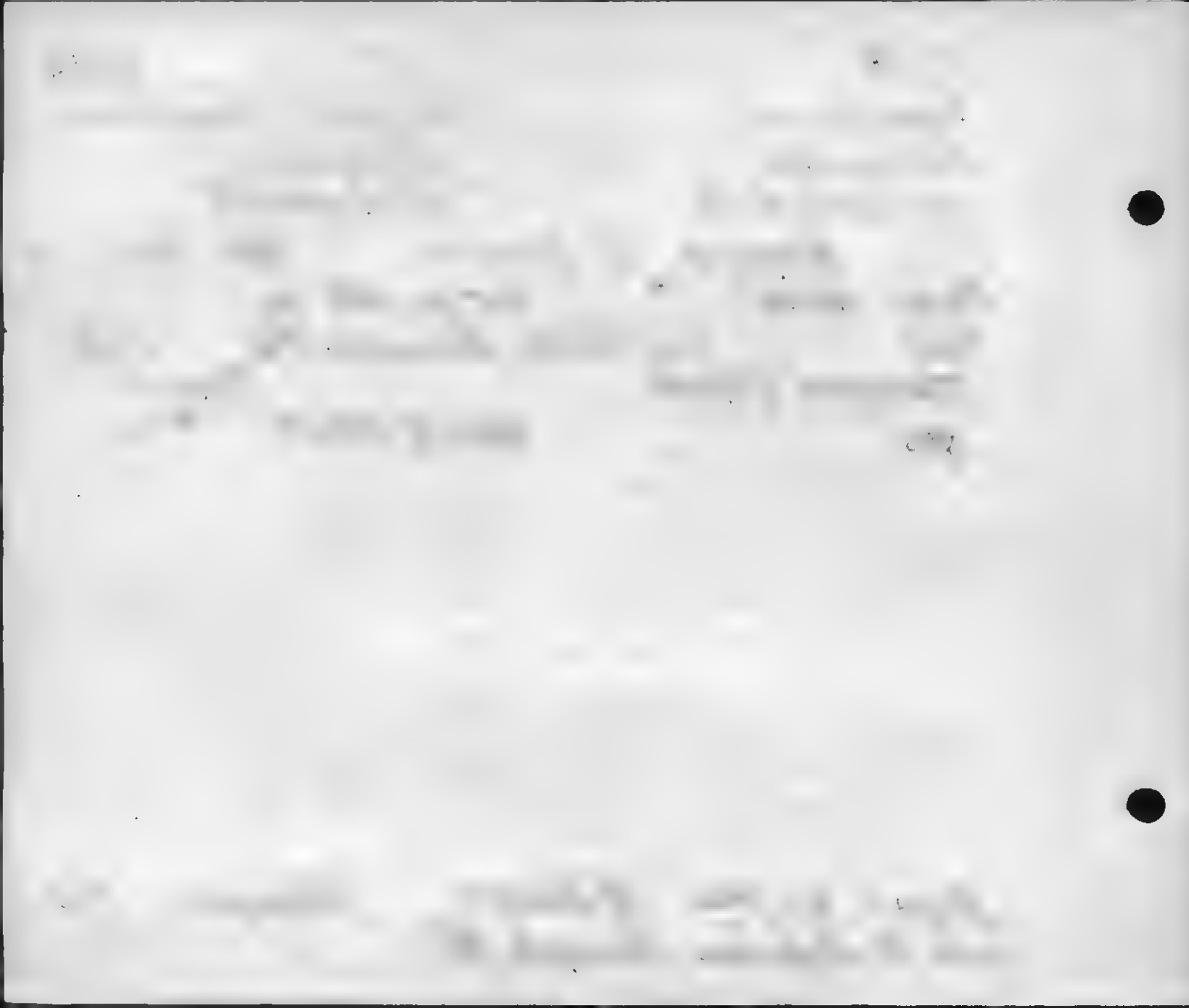
00114

00110

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>161 Conduit St.</u>				2. USUAL RESIDENCE (Where deceased lived at institutions; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>161 Conduit St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ARTHUR T. ELLIOTT</u>				4. DATE OF DEATH <u>JAN. 29 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 21, 1889</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retd.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Thompson Elliott</u>			
14. MOTHER'S MAIDEN NAME <u>DAVIS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>			
16. SOCIAL SECURITY NO. <u>155-2-1966</u>				17. INFORMANT <u>Mary C. Elliott</u> Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, <u>5 weeks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1965</u> to <u>Jan. 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 23 1966</u> , and that death occurred at <u>4 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John M. Taylor</u>				22b. DATE SIGNED <u>1/30/66</u>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-1-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>	
23d. LOCATION (City, town or county) <u>Annapolis</u>				23e. (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>				25a. REC'D BY REGISTRAR <u>55B 2</u>		25b. REGISTRAR'S SIGNATURE <u>1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

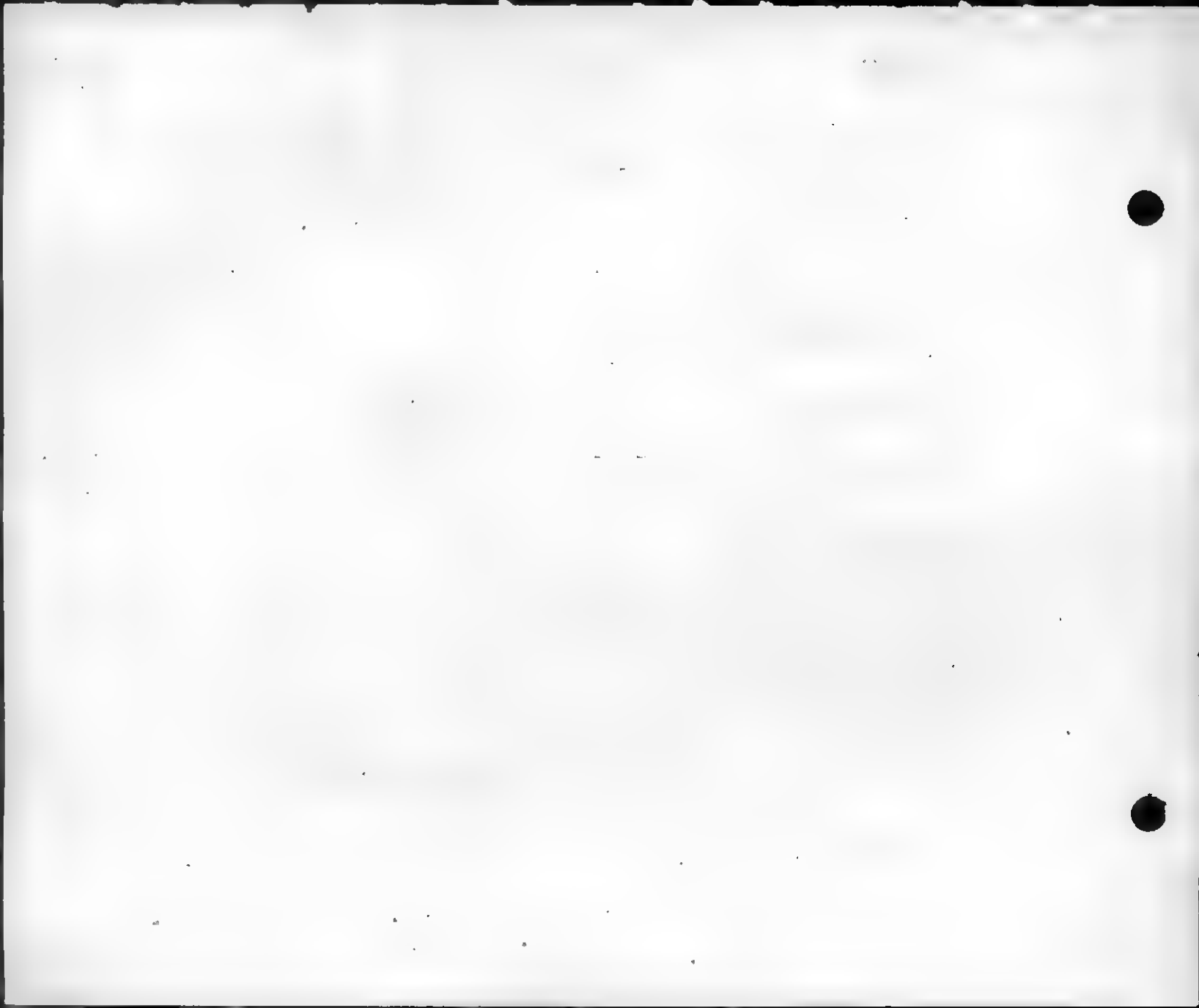


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 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00115						00111					
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FT GEORGE G MEADE</b> c. LENGTH OF STAY IN ID <b>13 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BOWIE</b> d. STREET ADDRESS <b>12305 SALEM LA.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>EVA</b>			First Middle Last <b>C. EMMERICH</b>			4. DATE OF DEATH <b>JAN 15 1966</b>			Month Day Year		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 April 1933</b>		9. AGE (in years last birthday) <b>32 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>LEO MELVIN LABARGE</b>						14. MOTHER'S MAIDEN NAME <b>Pauline TENNANT</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>069-24-3372</b>		17. INFORMANT <b>MAJ JOHN EMMERICH</b> Address <b>12305 SALEM LANE BOWIE, MD</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>4 DEC</b> , 19 <b>65</b> , to <b>15 JAN</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>15 JAN</b> 19 <b>66</b> , and that death occurred at <b>1:30AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <i>R. A. Robinson</i>						22b. DATE SIGNED <b>15 JAN 66</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>NEIL ROBINSON, CAPT, MC</b>						22d. ADDRESS <b>4 THORNTON CT BALTIMORE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Arlington Va.</b>		
24. FUNERAL DIRECTOR <b>Funeral Home Inc.</b>				24b. NAME <b>Nalley's</b>		24c. ADDRESS <b>Mt. Rainier Maryland</b>			25a. REC'D BY REGISTRAR <b>JAN 20 1966</b>		
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION



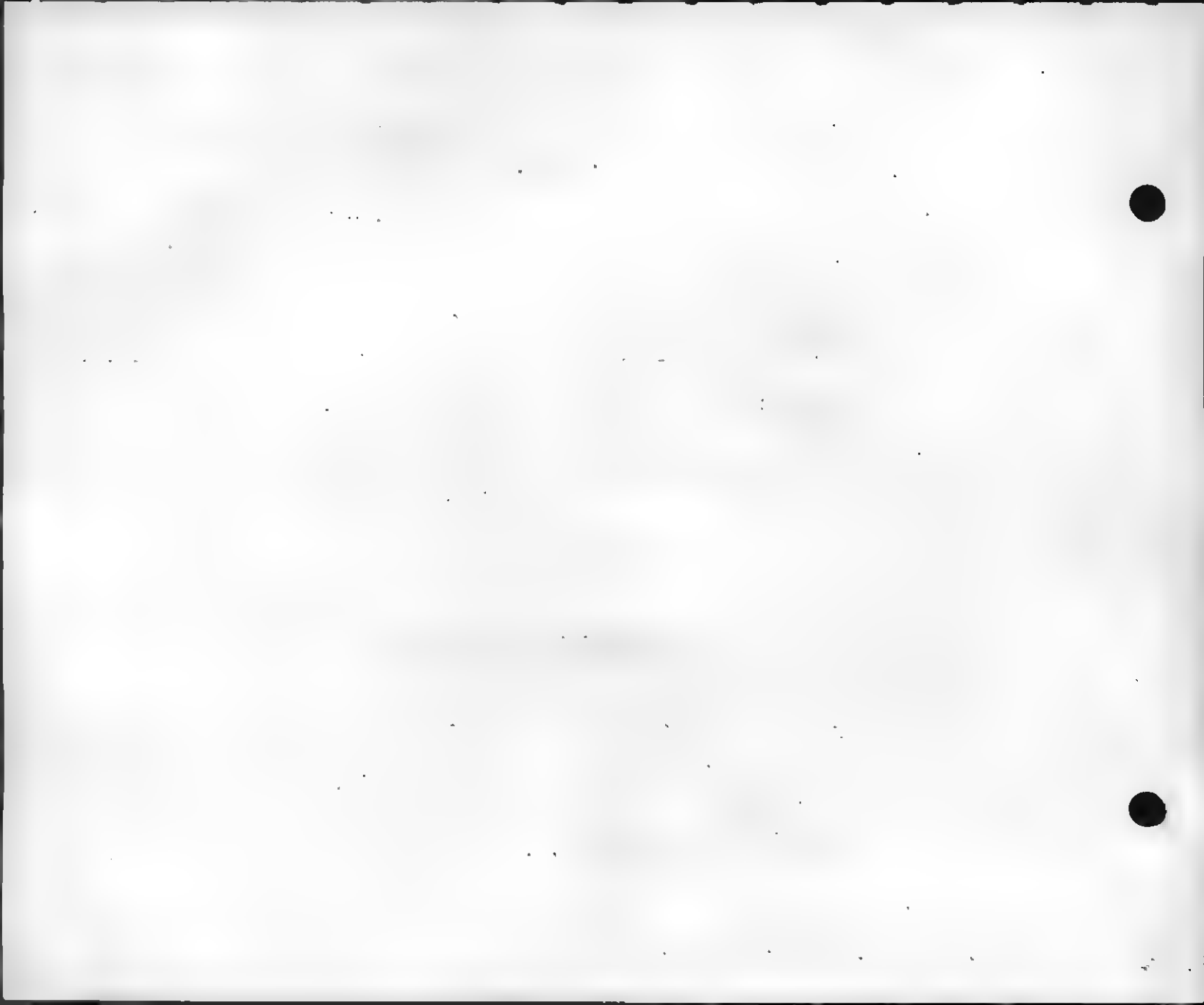


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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3yrs. 3mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						d. STREET ADDRESS 1111 N. Appleton Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#24306 Drucilla			First Middle Last Evans			4. DATE OF DEATH Month Day Year 1 26 1966					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1896		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard Hill						14. MOTHER'S MAIDEN NAME Willie A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity, Albuminemia, Schizophrenia											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11-- 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 10/4, 1962 to 1/26, 1966, that (I) (we) last saw the deceased alive on 1/26, 1966, and that death occurred at 12:20 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Lionel McHenry Mapp</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/27/66			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.						22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/66		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Md.					
24. FUNERAL DIRECTOR Arlington Phillips 1737 N. Monaca St.						25a. REC'D BY REGISTRAR DATE FEB 2 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00113

## CERTIFICATE OF DEATH

00113

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-- Mayo</b> c. LENGTH OF STAY IN b <b>18 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Anne Arundel</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Mayo</b> d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) <b>GEORGE JOHN FEY Sr.</b>		<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>19</b> Year <b>19 66</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Dec. 8, 1890</b>		<b>9. AGE (in years last birthday)</b> <b>75 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>IX</b> Days <b>XXX</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Government (U.S.)</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U.S. (Washington, D.C.)</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>		<b>13. FATHER'S NAME</b> <b>JOHN W. FEY</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>"Yunk"</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mr. Leroy W. Fey</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardiovascular Disease with Hypertension</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from Feb. 20, 1957, to Jan. 19, 1966, that (I) (we) last saw the deceased alive on Jan. 19, 1966, and that death occurred at 3:05 P.M. the causes and on the date stated above</b>							
<b>22a. SIGNATURE</b> <i>Sylvia M. Lim</i>		<b>22b. DATE SIGNED</b> <b>1-19-66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Sylvia M. Lim, M.D.</b>			
<b>22d. ADDRESS</b> <b>Rt. 1 Box 244 Edgewater, Md.</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>					
<b>23b. DATE THEREOF</b> <b>1-22-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>CEDAR HILL</b>		<b>23d. LOCATION (City, town or county)</b> <b>PRINCE GEORGE CO. MD.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John M. Taylor &amp; Sons</i>		<b>ADDRESS</b> <b>Annapolis, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 21 1966</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <i>James W. Judge</i>							

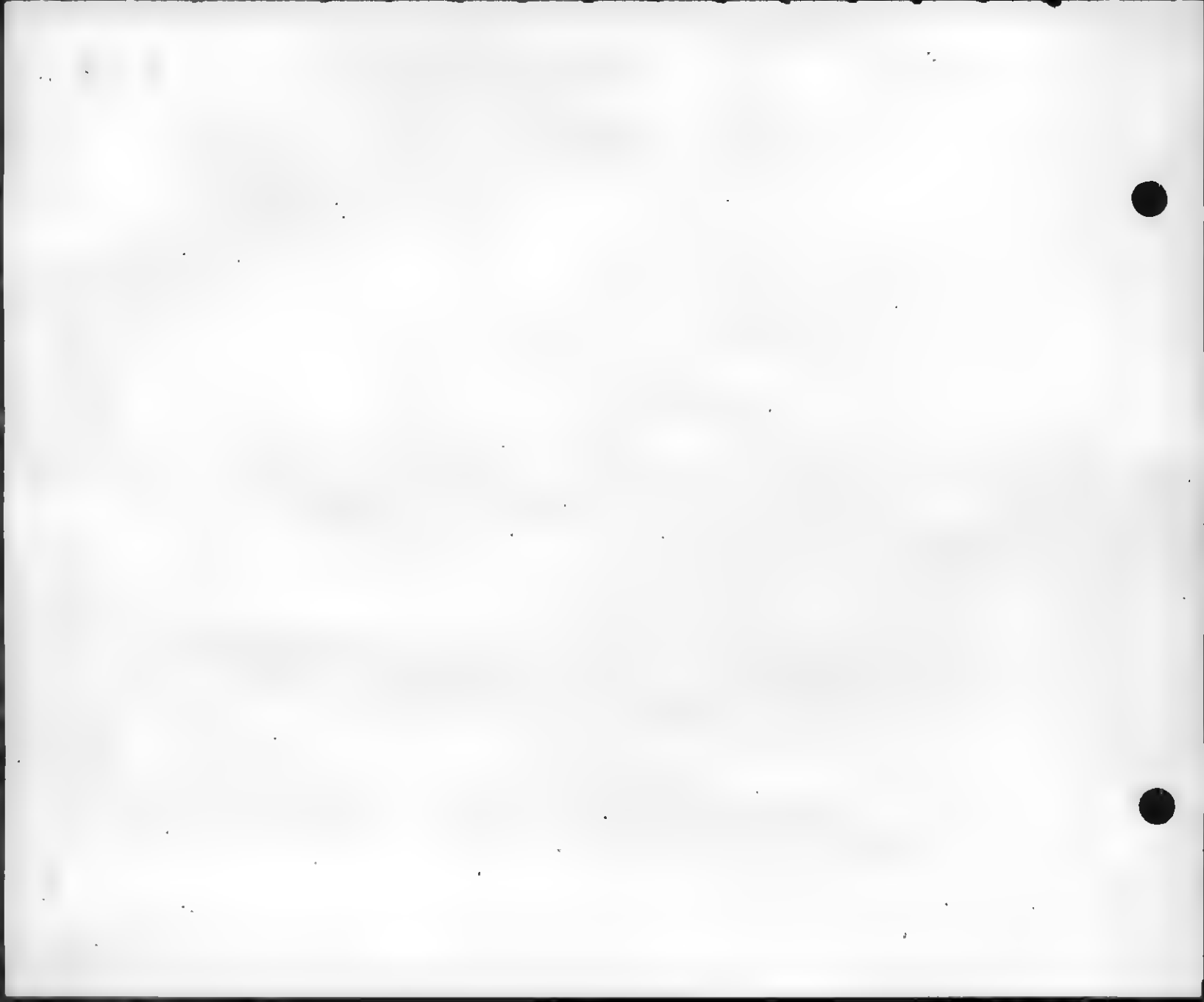
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00118 Items 13 & 14, Form 375-710/66 jml 00114										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>H.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> - 1 year					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>112 Helloys Drive</u>					d. STREET ADDRESS <u>112 Helloys Drive</u>					
3. NAME OF DECEASED (Type or print) First <u>James E.</u> Middle <u>Finch</u> Last <u>Finch</u>					4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 9 - 1897</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>15</u> Hours <u>15</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typographer Newspaper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Galveston Texas U.S.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nelson Wilbur Finch</u>					14. MOTHER'S MAIDEN NAME <u>Justine Helen Finch</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>111-111111111</u>					
17. INFORMANT <u>Elaine</u>					Address <u>112 Helloys Drive</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Generalized Carcinomatosis</u> <u>150X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca esophagus</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										
INTERVAL BETWEEN ONSET AND DEATH <u>None</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>66</u> , to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-23-66</u> 19 <u>66</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Robert R. Hahn</u>					22b. DATE SIGNED <u>1-27-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>					22d. ADDRESS <u>P.O. Box 73 Severna Park Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
<u>Robert R. Hahn</u>			<u>112 Helloys Drive</u>		<u>DATE FEB 1 1966</u>			<u>John R. George</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

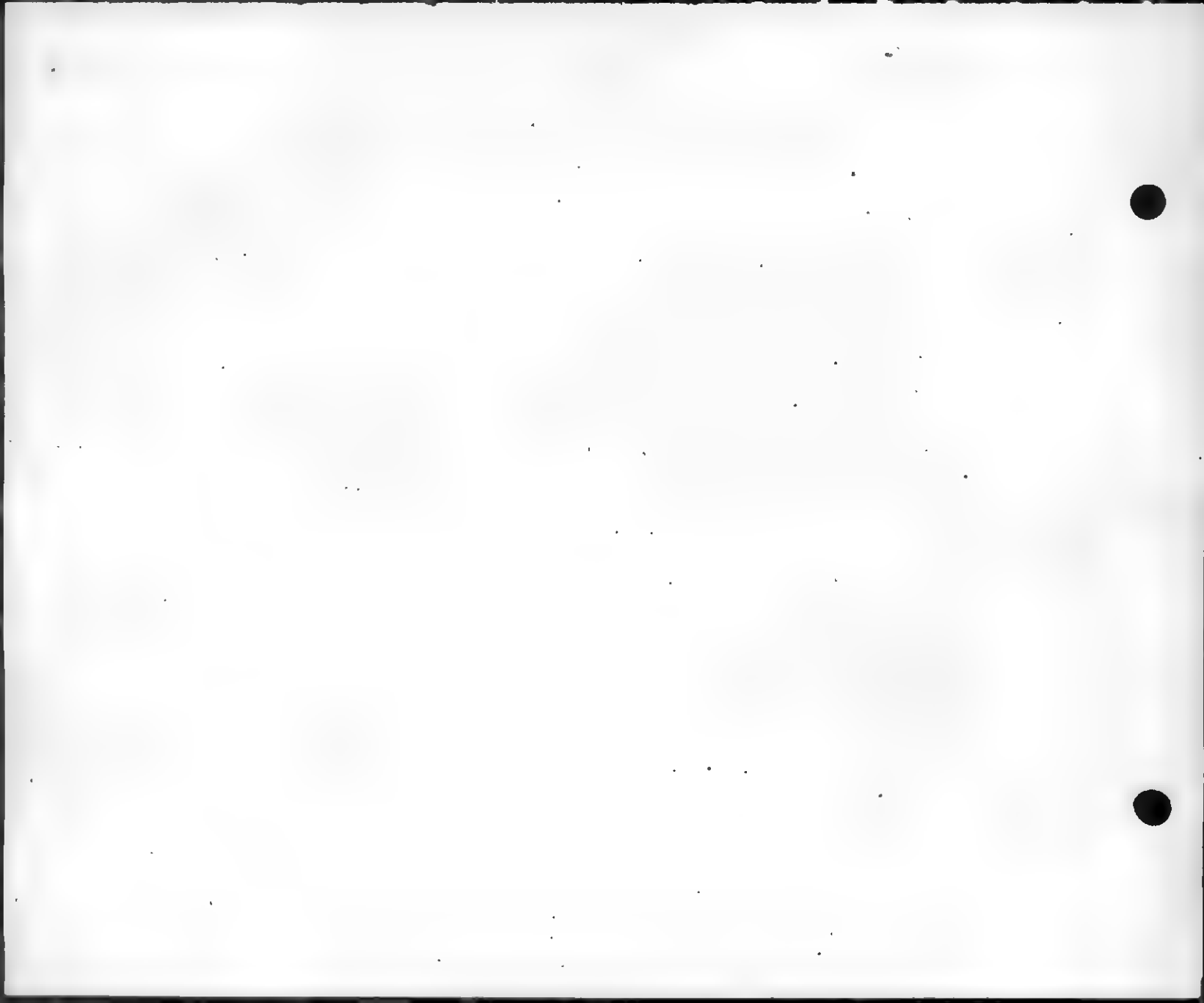
VR A15 (4)  
20M 1/65

00119

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00119

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u> c. LENGTH OF STAY IN 1b <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Arundel Plaza</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>W.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>Arundel Plaza</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Andrew JACKSON Fisher</u> First Middle Last			4. DATE OF DEATH <u>1-15-66</u> Month Day Year				
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>January 15, 1921</u>		9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Calif.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Joseph E. Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Tongdode</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>U.S. Navy 6 yrs</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Dr. Robert R. Halpin</u> Address <u>---</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive Pulmonary Malignancy</u> (c) <u>Cx Breast</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-14-66</u> , 19 <u>65</u> , to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-14-66</u> , 19 <u>66</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Halpin</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-15-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HALPIN</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-19-66</u>		23b. DATE THEREOF <u>1-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arundel Nat'l</u>			
23d. LOCATION (City, town or county) <u>Arundel</u>		(State) <u>MD</u>		24. FUNERAL DIRECTOR <u>Robert R. Halpin</u> ADDRESS <u>---</u>			
25a. REC'D BY REGISTRAR <u>18</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00120

00116

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FT. MEADE</u>				c. LENGTH OF STAY IN 1b <u>TESSUP</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KIMBROUGH ARMY HOSP.</u>				e. STREET ADDRESS <u>RT. 2</u>			
3. NAME OF DECEASED (Type or print) <u>JAMES WOODLAND FLEMING</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/18/85</u>	9. AGE (In years last birthday) <u>80</u> yrs.	10. FUNERAL 1 YEAR Months <u>1</u> Days <u>16</u> Hours <u>16</u> Min.	11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE OF MD. GUARD - RET.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			
13. FATHER'S NAME <u>ALLISON T. FLEMING</u>				14. MOTHER'S MAIDEN NAME <u>MOLLY MILLS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>ZIPPORAH FLEMING</u>			
17. INFORMANT <u>WIFE</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-13</u> , 19 <u>66</u> , to <u>1-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-13</u> , 19 <u>66</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Kyle Y. Swisher Jr</u>				22b. DATE SIGNED <u>1-16-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Kyle Y. Swisher Jr</u>				22d. ADDRESS <u>UNIV. HOSP. - Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1/19/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>				23d. LOCATION (City, town or county) (State) <u>HOWARD CO. Md.</u>			
24. FUNERAL DIRECTOR <u>E. S. MALIVARR</u>				25a. REC'D BY REGISTRAR <u>301 FREDERICK RD</u>			
25b. REGISTRAR'S SIGNATURE <u>21228</u>				25c. DATE <u>19 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						d. STREET ADDRESS 223 Silver Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#31131			First Sophia			Middle Rice			Last Fleming		
4. DATE OF DEATH Month 1			Day 30			Year 1966					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1892		9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Almstead Rice						14. MOTHER'S MAIDEN NAME Mary					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4-1-1 DUE TO Hypertensive Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to the above, Dehydration											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -----							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/18, 1966, to 1/30, 1966, that (I) (we) last saw the deceased alive on 1/30, 1966, and that death occurred at 1:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Lionel McHenry</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry, M.D.						22b. DATE SIGNED 1/30/66					
22d. ADDRESS Crownsville State Hospital, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-66		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		23d. LOCATION (City, town or county) Balto.		(State) Md.			
24. FUNERAL DIRECTOR E.O. Walcott						ADDRESS 1000 Brantley Ave.		25a. REC'D BY REGISTRAR DATE FEB 28 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

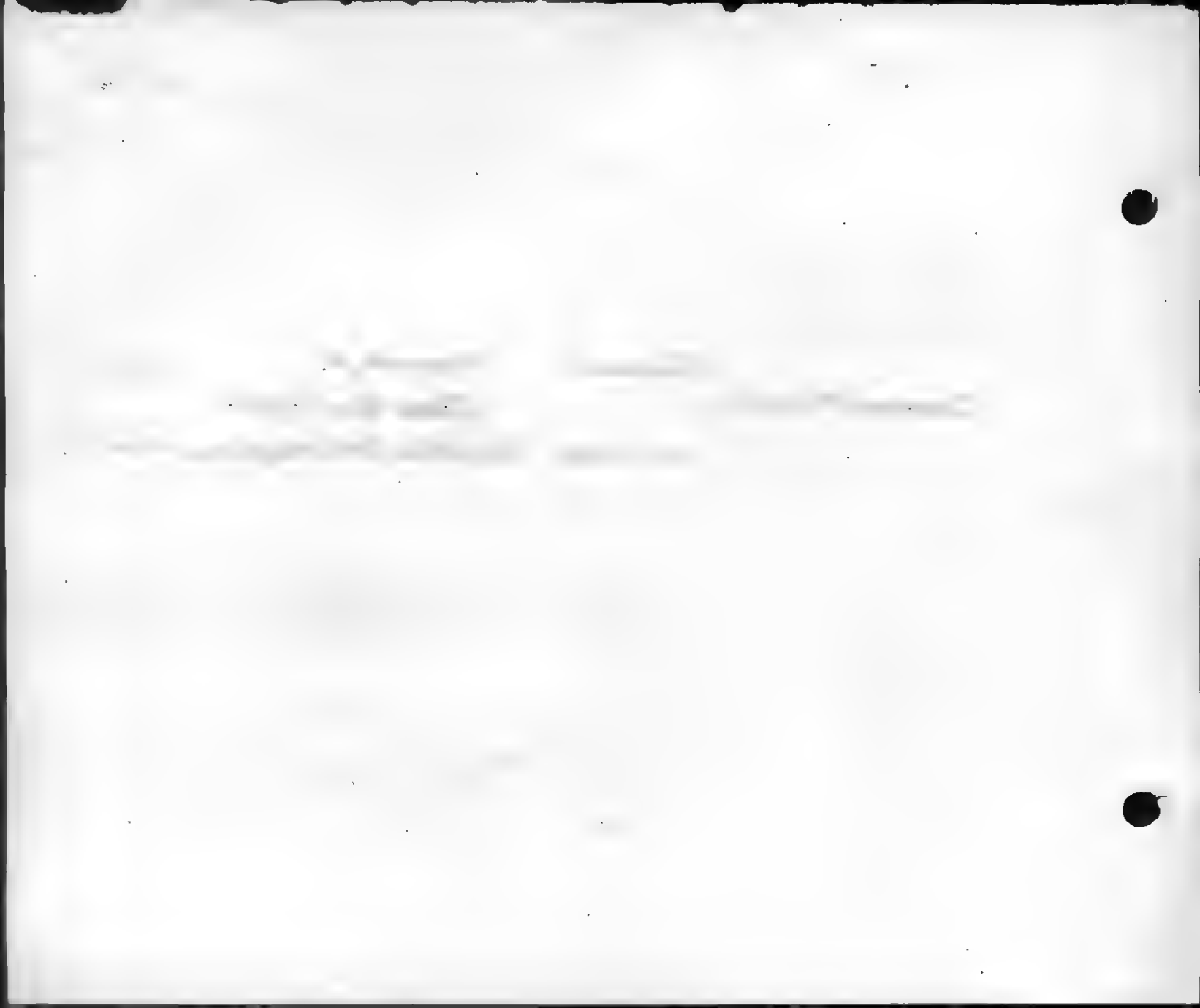


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00122 CERTIFICATE OF DEATH 00117

1. PLACE OF DEATH a. COUNTY <u>AA Co</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAPE ST. LAIRE ANNAPOLIS, MD.</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs</u>		d. STREET ADDRESS <u>176 River Bay Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERHARD Phillip Fox</u>		4. DATE OF DEATH Month Day Year <u>JAN 26 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 3, 1924</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Elizabeth, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GERHARD Philip Fox</u>		14. MOTHER'S MAIDEN NAME <u>CLARA MAE Horton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>156-01-0640</u>	
17. INFORMANT <u>Betty M. Fox</u>		Address <u>176 River Bay Rd. Cape St. Claire, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> <u>4001</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency (angina pectoris)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>6 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>first death</u> , 19 <u>was 1-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>January 25 1966</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bertrand C. R. Gau</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-26-66</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JAN 31, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, VA.</u>
24. FUNERAL DIRECTOR <u>Thomas Hardisty 12 Ridgely Ave Annapolis, Md</u>		25a. REC'D BY REGISTRAR <u>F-5 2</u>	25b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



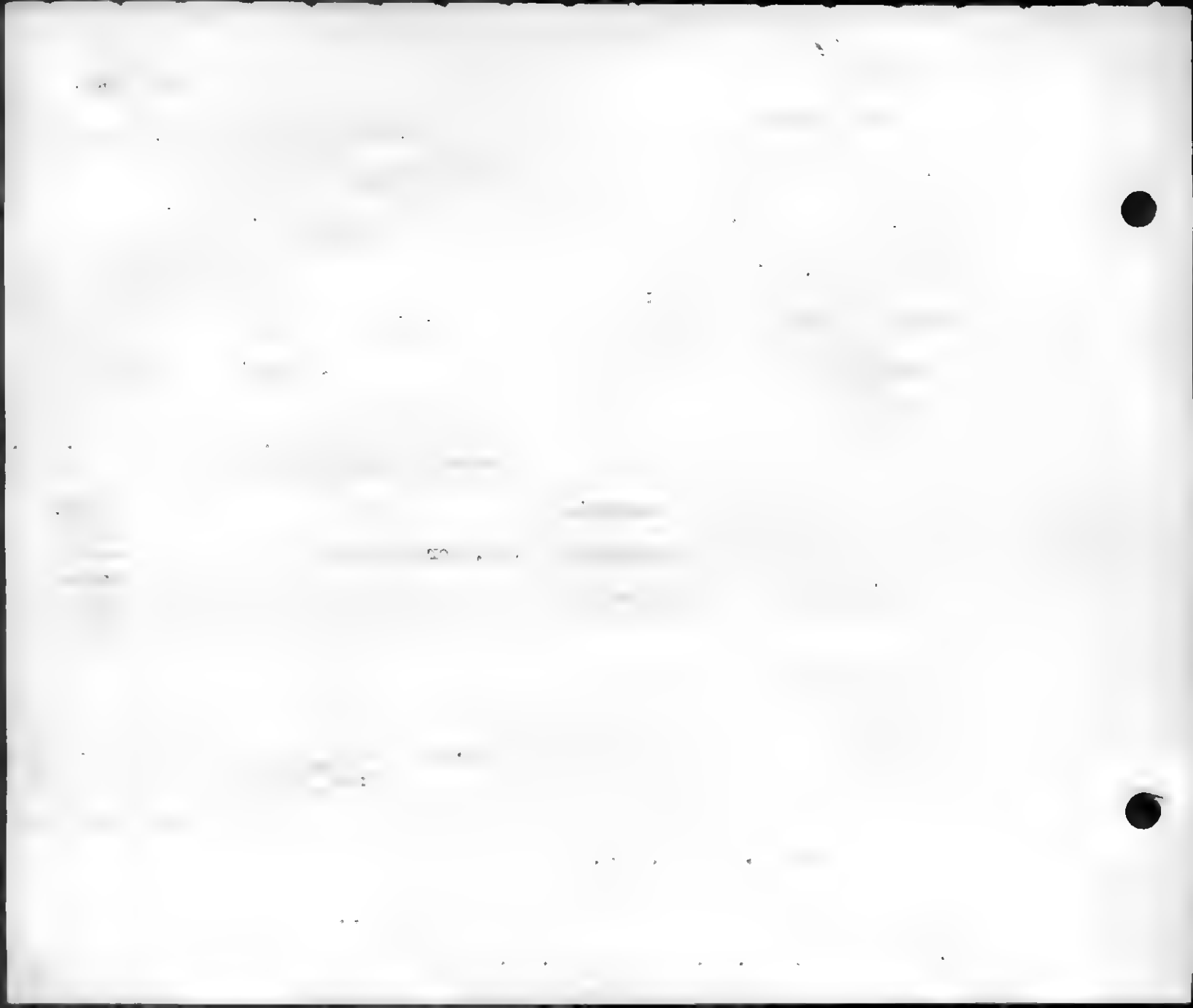
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00123

00118

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort George G Meade</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kimbrough Army Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>1216 Montgomery Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Hazel</b> <b>Frank</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>January 15 1966</b> Month Day Year	
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>cau</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>13 May 1914</b>
<b>9. AGE</b> (In years last birthday) <b>51 yrs.</b> IF UNDER 1 YEAR: Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>N. Carolina</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Land</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary ----</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>577 28 4512</b> <b>17. INFORMANT</b> <b>1216 Montgomery Dr., Glen Burnie, Md.</b> <b>Isadore Frank (husband)</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema severe, Cat Pulmonale</b> DUE TO (c) <b>Asthma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3 January 1966</b> , <b>to</b> <b>15 January 1966</b> , <b>that</b> <b>we</b> <b>last saw the deceased alive on</b> <b>15 January 1966</b> , <b>and that death occurred at</b> <b>9:10 AM</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>ROALD A. NELSON, MAJ, MC</b>		<b>22b. DATE SIGNED</b> <b>15 January 1966</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b>		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/18/66</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National Cem. Arlington, Virginia</b>		<b>23d. LOCATION (City, town or county) (State)</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Bernard Danzansky &amp; Sons</b> <b>3501 14th St., N. W., Wash., D. C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





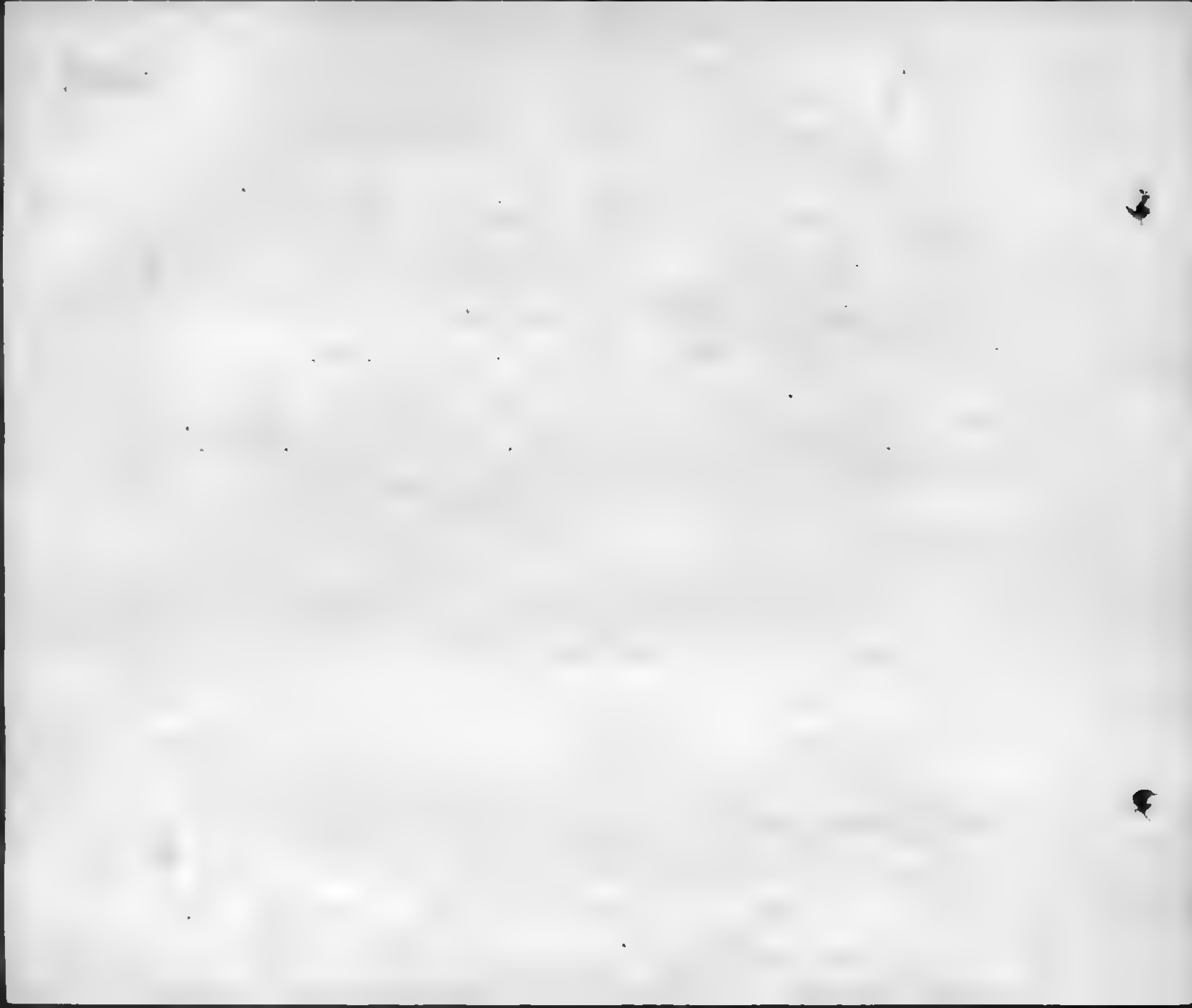
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <i>AA CO</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA CO</i>				<b>00119</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockat-Glen Burial</i>				c. LENGTH OF STAY in 1b <i>1</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A. - NORTH ARCADE L.</i>				d. STREET ADDRESS <i>Severn, Md. Bay 250-Clark Station</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>William</i> Middle <i>A.</i> Last <i>Franke</i>				<b>4. DATE OF DEATH</b> Month <i>1</i> Day <i>27</i> Year <i>1966</i>							
<b>5. SEX</b> <i>male</i>		<b>6. COLOR OR RACE</b> <i>white</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>Sept. 4, 1893</i>		<b>9. AGE</b> (In years last birthday) <i>72</i> yrs.		<b>IF UNDER 1 YEAR</b> Months <i>1</i> Days <i>27</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Chicken Business Own</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Baltimore, Md.</i>				<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <i>August F. Franke</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Christina Zang</i>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <i>yes W.W.I Army</i>				<b>16. SOCIAL SECURITY NO.</b> <i>none</i>				<b>17. INFORMANT</b> <i>138 N. Kenwood Ave., 21224 Mrs. Anna T. Hutson, neice,</i>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerosis generalized</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I or 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <i>19</i>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <i>E. Linhard</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <i>1.27.66</i>			
<b>EXAMINER'S NAME</b> (Type) <i>E. Linhard</i>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>				<b>22b. DATE THEREOF</b> <i>1/31/66</i>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>Glen Haven Mem. Park</i>		<b>22d. LOCATION</b> (City, town, or country) (State) <i>Baltimore, Md.</i>			
<b>23. FUNERAL DIRECTOR</b> <i>Schimunek Funeral Home, Inc.</i> <i>3331 Brehms Lane</i>						<b>24a. REC'D BY REGISTRAR</b> <i>1966</i> <b>24b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>					

MEDICAL CERTIFICATION



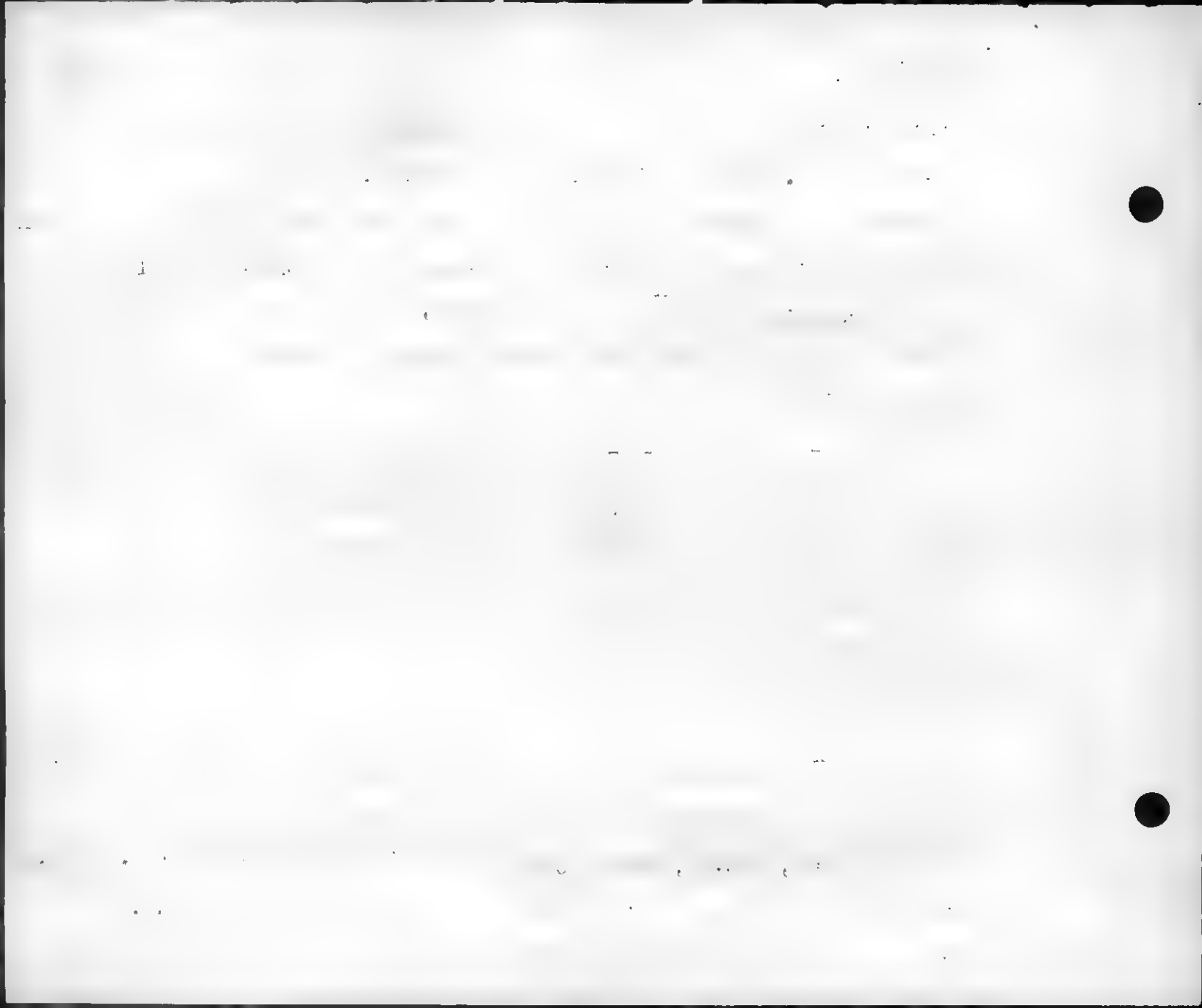
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN ID <b>15 d</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Odenton, Maryland</b>		d. STREET ADDRESS <b>539 Maple Ridge Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NATHAN RICHARDSON GARLAND</b>		4. DATE OF DEATH <b>January 11 1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 3, 1888</b>		9. AGE (in years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hennebin, Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John T Garland</b>		14. MOTHER'S MAIDEN NAME <b>Richardson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>303-07-6403</b>		17. INFORMANT <b>Mrs Elizabeth M Garland</b>		Address <b>Wife same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4 IX DUE TO (b) <b>Staphylococcal Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of Prostate</b>												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>27 December 1965</b> to <b>11 January 1966</b> , that (I <del>last</del> ) saw the deceased alive on <b>11 January 1966</b> , and that death occurred at <b>9:40 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Paul K. Berg</b>		22b. DATE SIGNED <b>Jan 11, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>PAUL K BERG, Captain, Medical Corps</b>		22d. ADDRESS <b>Kimbrough Army Hosp, Ft Geo G. Meade, Md</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>		24. FUNERAL DIRECTOR <b>HOPPING FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>ANNAPOLIS, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>J. M. Jones</b>		25c. DATE <b>JAN 17 1966</b>		25d. REGISTRAR'S SIGNATURE <b>J. M. Jones</b>		25e. DATE <b>JAN 17 1966</b>		25f. REGISTRAR'S SIGNATURE <b>J. M. Jones</b>		25g. DATE <b>JAN 17 1966</b>		25h. REGISTRAR'S SIGNATURE <b>J. M. Jones</b>		25i. DATE <b>JAN 17 1966</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00121

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #1 - Box 109		d. STREET ADDRESS RFD #1 - Box 109	
3. NAME OF DECEASED (Type or print) JAMES OLIVER GRIMES		4. DATE OF DEATH 1 4 19 66	
5. SEX Male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DATE OF BIRTH 1902 63 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) florist helper		10b. KIND OF BUSINESS OR INDUSTRY greenhouse	
11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marshall Grimes		14. MOTHER'S MAIDEN NAME Sarah Rose Paul	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMATION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head 176X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Interval between ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Shot self in head		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1-4 19 66		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Radiger Breitenecker, M.D.		DATE SIGNED 1-5-66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-66	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem.		22d. LOCATION (City, town, or country) (State) Ellicott City Md.	
23. FUNERAL DIRECTOR De Witt Canadon, Laurel, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

JAN 10 1966



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

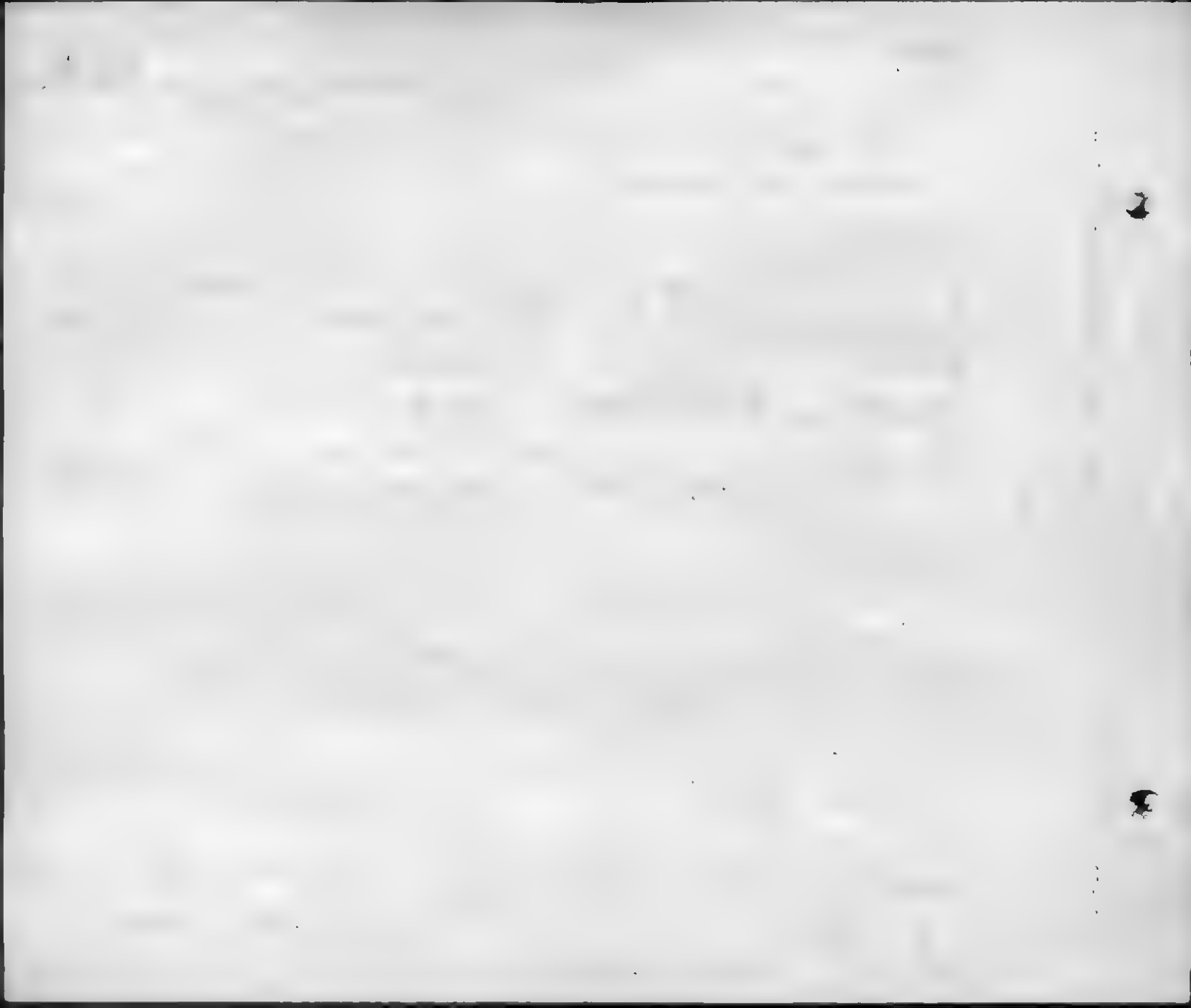
00127

## CERTIFICATE OF DEATH

00122

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>THREE MILE OAK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DEFENSE Highway</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>THREE MILE OAK</u> d. STREET ADDRESS <u>DEFENSE Highway</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>JENNIE R. GRIMES</u>		<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>6</u> Year <u>1966</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-4-1888</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Artist</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>	
<b>13. FATHER'S NAME</b> <u>SAMUEL RICHARDSON</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MINNIE B. PALMER</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>INFORMANT</u> <u>OSCAR F. GRIMES #2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>11-29-66</u>, 19<u>66</u>, to <u>1-6-</u>, 19<u>66</u>, that (I) <del>(we)</del> last saw the deceased alive on <u>1-6-</u>, 19<u>66</u>, and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>M.P. Stephens</u>		<b>22b. DATE SIGNED</b> M.D. <u>1-6-66</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>1-9-66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>EDWARDS CHAPEL</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>ANNAPOLIS MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Taylor &amp; Sons</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 11 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b>		<b>25c. REGISTRAR'S SIGNATURE</b>	

TO HOSPITAL ATTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

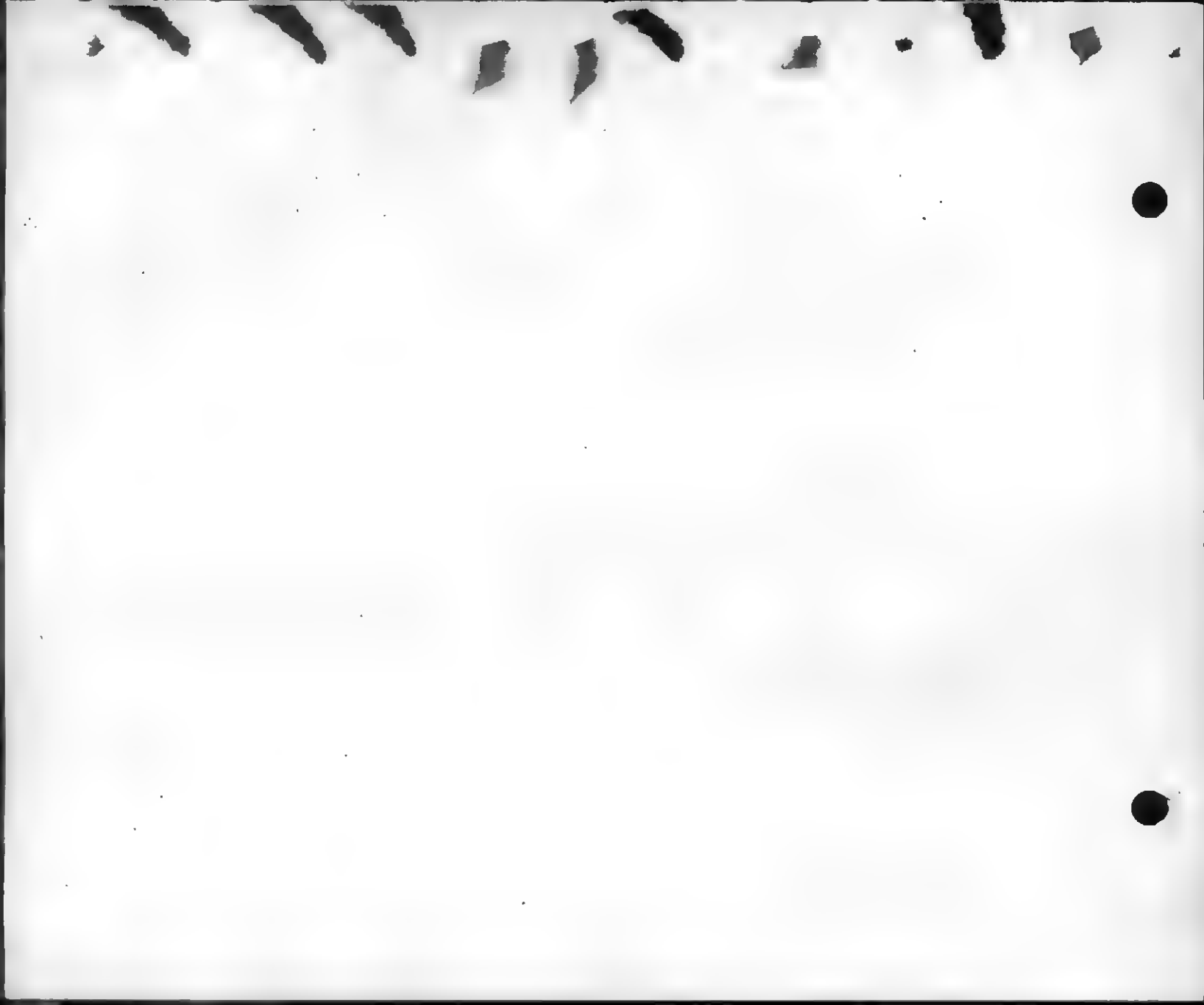




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
00128		00123											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN ID <u>10 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hosp.</u>						d. STREET ADDRESS <u>240 WANDA ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>A</u> Last <u>Haddaway</u>						4. DATE OF DEATH Month <u>January</u> Day <u>29th</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/27/10</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Charles Haddaway</u>						14. MOTHER'S MAIDEN NAME <u>Mathilda Skohell</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-07-4950</u>		17. INFORMANT <u>Hospital char</u> Address <u></u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>19th Jan, 1966</u> to <u>29th Jan, 1966</u> , that (I) (we) last saw the deceased alive on <u>29th Jan 1966</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Alvin Thompson</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/29/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Alvin Thompson</u>						22d. ADDRESS <u>Crownsville State Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-3-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>STILL POND, CEMT</u>		23d. LOCATION (City, town or county) <u>STILL POND, MD</u>		(State)					
24. FUNERAL DIRECTOR <u>Funeral Home</u>						ADDRESS <u>Still Pond, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/70

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00129

00124

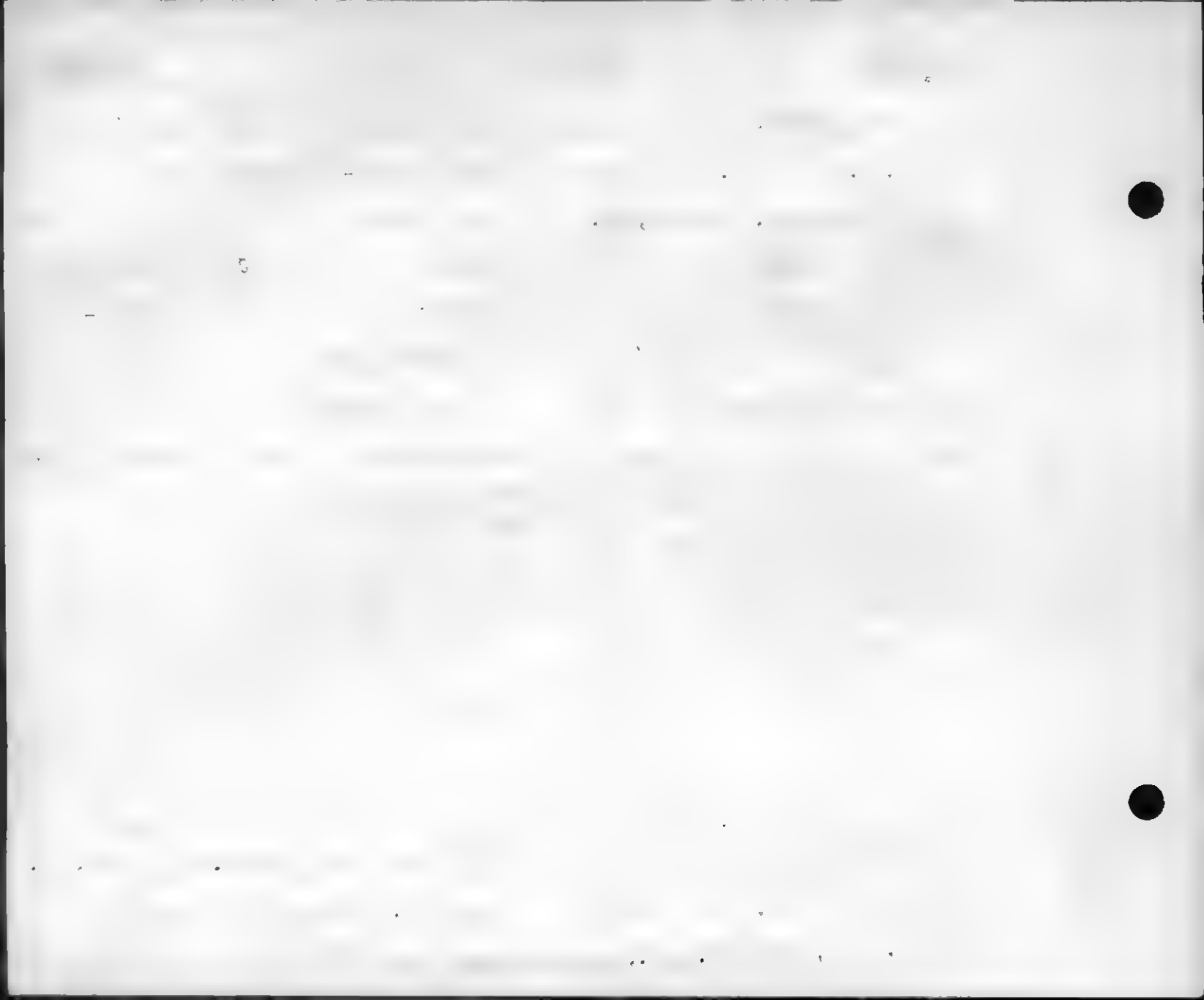
1. PLACE OF DEATH a. COUNTY <u>AA</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Deale Beach, Churchton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Deale Beach, Churchton, MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John Francis Hafford</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>July 2 1882</u>	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <u>83</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov't</u>	
11. BIRTHPLACE, County & State, or foreign country <u>Plattsburg NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Hafford</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann McKillip</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>215 406 117</u>	
17. INFORMANT <u>Harriet T Hafford, Churchton Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Cerebral Vascular Accident</u> <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs 45</u> <u>unk</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>60</u> , to <u>3 Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>27 Dec</u> , 19 <u>65</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 7 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Sorrows</u>		23d. LOCATION (City, town or county) (State) <u>Owensville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Handy's Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Jan 12 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film G378 6/2/66 97  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00130 CERTIFICATE OF DEATH 00125

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>KENTUCKY</b> b. COUNTY <b>LETCHER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT GEO. G. MEADE, MD.</b>		c. LENGTH OF STAY IN 1b <b>3 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EOlia (RURAL-WHITESBURG CITY)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1616F FORREST AVE, FT MEADE, MD.</b>				d. STREET ADDRESS <b>RURAL ROUTE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>REED</b> Last <b>HAMPTON</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>29</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 OCT 65</b>		9. AGE (In years last birthday) <b>0 yrs.</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b> Hours <b>-</b> Min. <b>-</b>	IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MUNICH, GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>NEWELL REED HAMPTON</b>				14. MOTHER'S MAIDEN NAME <b>ERIKA BERTALANICS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT Address <b>NEWELL HAMPTON 1616F FORREST AVE, FT MEAD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DEATH OF UNDETERMINED ORIGINS</b> DUE TO <b>PENDING AUTOPSY REPORT/</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>"Crib death"</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							22b. DATE SIGNED
22a. SIGNATURE <b>SIDNEY SHANKMAN/CAPT/MC</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>29 JAN 66</b>	
22c. PHYSICIAN'S NAME (Typed) <i>Sidney Shankman, Capt MC</i>		22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL, FT MEADE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2 Feb. 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON, VIRGINIA</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>				25a. REC'D BY REGISTRAR <b>29 JAN 66</b>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film G373 2/1/66											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00131 CERTIFICATE OF DEATH 01672											
1. PLACE OF DEATH a. COUNTY <u>CROWNSVILLE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>						d. STREET ADDRESS <u>1618 E. EAGER ST</u>					
3. NAME OF DECEASED (Type or print) <u>CLIFTON M. HARRIS</u>						4. DATE OF DEATH <u>JAN. 28 1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 1, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMMETT HARRIS</u>						14. MOTHER'S MAIDEN NAME <u>MARY HARRIS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO <u>SEPTICEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Decubital ulcers, multiple</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME SEC. CEREBRAL ARTERIOSCLEROSIS</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-21, 1966</u> to <u>1-28, 1966</u> that (I) (we) last saw the deceased alive on <u>1-28, 1966</u> and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED <u>1/29/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>C. BENEDICT M.D.</u>						22d. ADDRESS <u>Crownsville State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>Feb 3 1966</u>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State) <u>Petersburg Va.</u>	
24. FUNERAL DIRECTOR <u>Frank P. Election 1129 N. Carolina St</u>						25a. REC'D BY REGISTRAR <u>CB 8</u> 1966					
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											





10

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00132

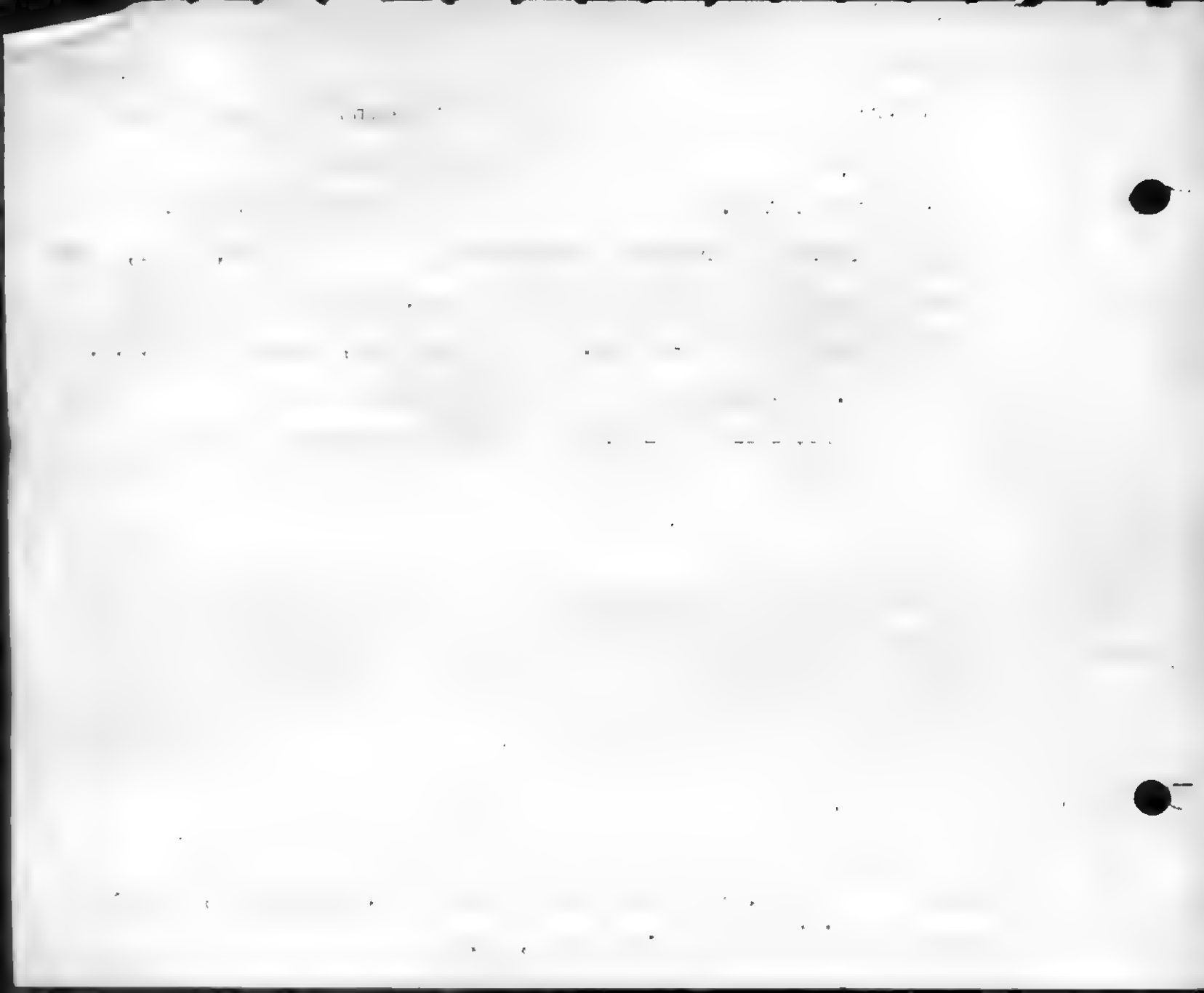
CERTIFICATE OF DEATH

00126

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>North Arundel Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>407 E Furnace Branch Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Louis Sylvester Hartenstein</b>		4. DATE OF DEATH <b>Jan. 1, 1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>31 Dec. 1905 60</b>		9. AGE (in years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Emp.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Hartenstein</b>						14. MOTHER'S MAIDEN NAME <b>Tillie (Unknown)</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>-----</b>				16. SOCIAL SECURITY NO. <b>219-32-1911</b>		17. INFORMANT <b>Elizabeth Hartenstein (wife)</b> Address <b>-----</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarct</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <b>ASCVD</b> DUE TO (c) <b>-----</b>										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>12 Jan</b> , 1966, to <b>13 Jan</b> , 1966, that (I) (we) last saw the deceased alive on <b>13 Dec 65 19</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>[Signature]</b>										22b. DATE SIGNED <b>3 Jan 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>A R. Sosnowski</b>										22d. ADDRESS <b>4016 Ritchie Hwy #25-Beth</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5 Jan. 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>				23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b>					
24. FUNERAL DIRECTOR <b>R.V. Singleton</b>						ADDRESS <b>Singleton Funeral Home/ Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
DATE <b>JAN 5 1966</b>													



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00133

00127

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>26 Bunche St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Joshua</b> Middle <b>ISAAC</b> Last <b>HAYES</b>				4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2-1905</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel - Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Perry Hayes</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Murray</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-18-2104 A</b>		17. INFORMANT Address <b>Rosalee C. Hayes-26 Bunche St. Anna. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Alcoholism causing cirrhosis of liver</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>Indefinite</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>was present</del> attended the deceased from <b>1/26/66</b> , 19 <b>66</b> , to <b>1/26</b> , 1966; that (I) <del>last</del> saw the deceased alive on <b>1/26</b> , 1966, and that death occurred at <b>3:21 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Gerard Church</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerard Church, M.D.</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 2-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Broadneck Meth. Church</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis-A.A.Co. Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>C.E. Hicks 111 Annapolis, Md.</b>				25a. REC'D BY REGISTRAR <b>Feb 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>William Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO NOTIFY OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

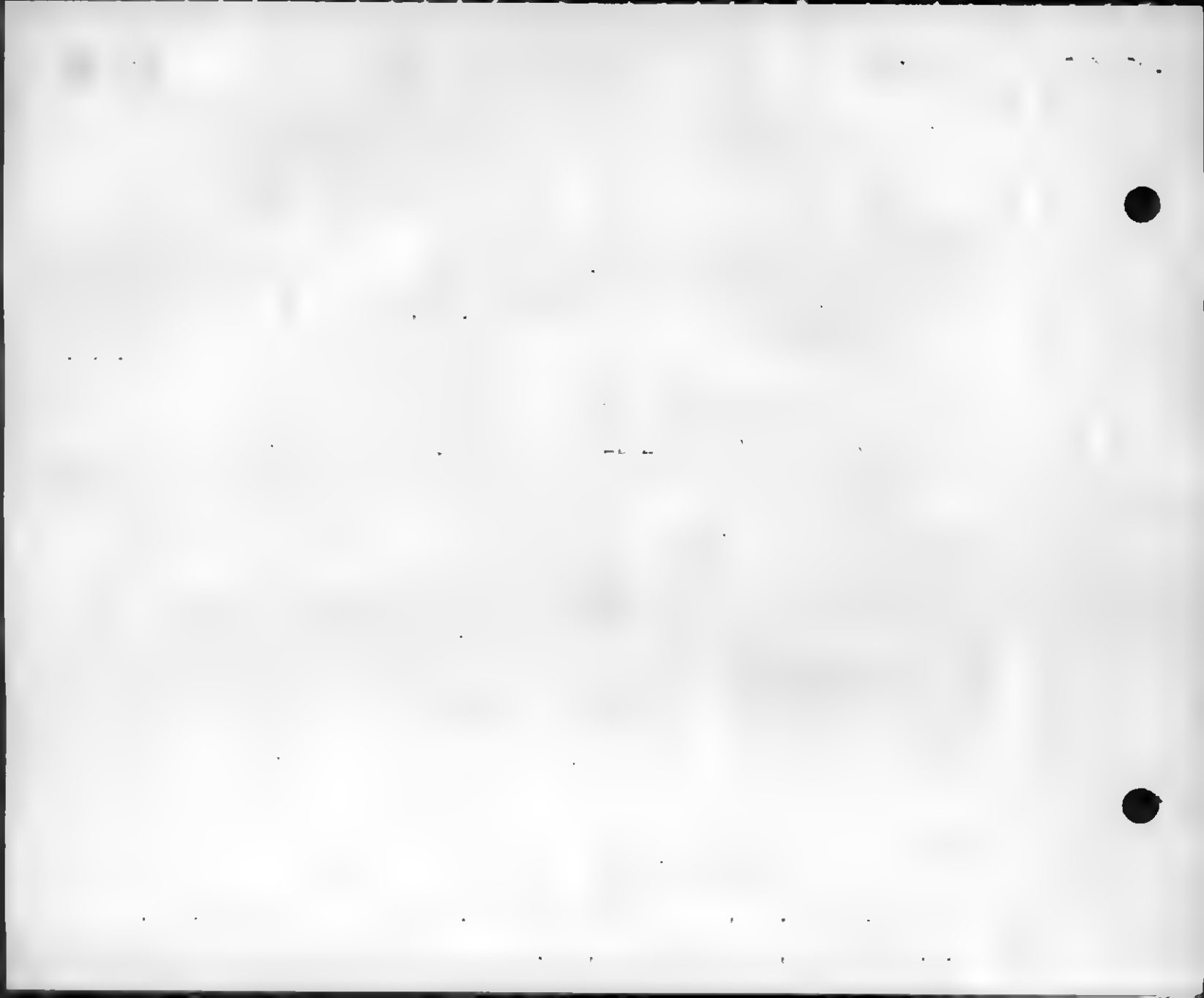
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00134

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00128

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN ID		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 120 CARROLL ROAD				d. STREET ADDRESS 120 CARROLL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILORED Middle F. Last HERPEL		4. DATE OF DEATH Month JANUARY Day 8 Year 1966					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1924	9. AGE (in years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERBERT SANFORD NULL				14. MOTHER'S MAIDEN NAME BESSIE VIRGINIA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 230-14-0510		17. INFORMANT JOHN F. HERPEL SAME AS # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Coronary arteriosclerotic heart disease</i> DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH 4 hours 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1950</i> to <i>January 8, 1966</i> , that (I) (we) last saw the deceased alive on <i>January 10, 1966</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>R. M. McLaughlin</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/8/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>				22d. ADDRESS <i>3768 Mountain Road, Pasadena, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 12, 1966		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		23d. LOCATION (City, town or county) (State) GLEN BURNIE, MD.	
24. FUNERAL DIRECTOR R.V. SINGLETON, GLEN BURNIE, MD.				25a. REC'D BY REGISTRAR JAN 14 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

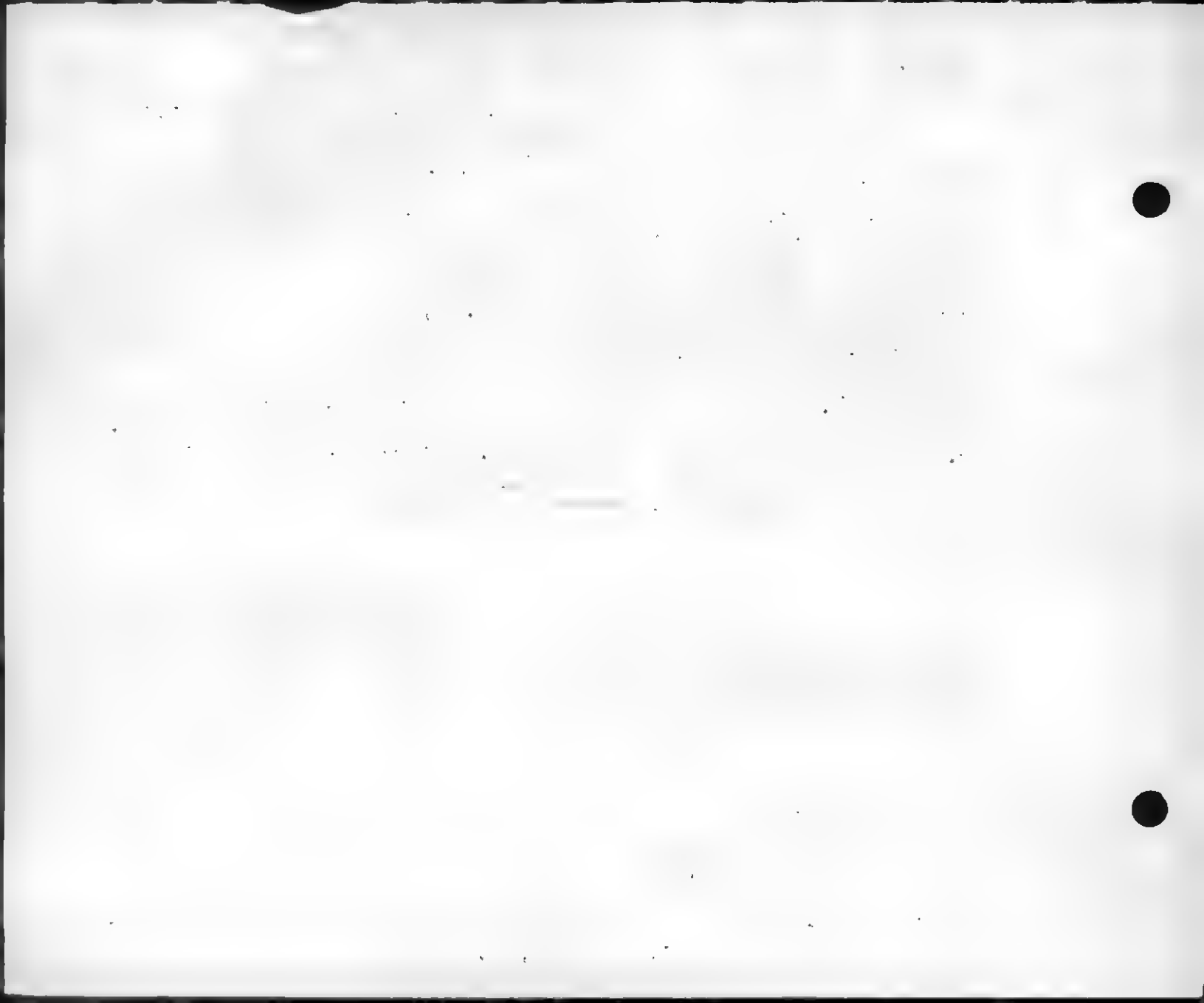
00135

00129

1. PLACE OF DEATH a. COUNTY <i>AA Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>RURAL - Glen Burnie</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>RURAL - Glen Burnie</i>	
c. LENGTH OF STAY IN 1b <i>001 - North. Arundel - Hosp.</i>		d. STREET ADDRESS <i>8026 Fiddlers Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Paul</i> Middle <i>IK</i> Last <i>Higdon</i>		4. DATE OF DEATH Month <i>1</i> Day <i>27</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 26, 1904</i>
9. AGE (in years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George W. Higdon</i>		14. MOTHER'S MAIDEN NAME <i>Lydia J. Creighton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Glen Burnie, Md.</i>		<i>Mrs. Amelia Kaplan, 20 Birch Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Patent Schistosomiasis</i> <i>4500</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i></i> DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i></i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. L. Higdon</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Higdon</i>		Address (Street, city, town, or county) <i>1/21/66</i>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>Burial 1/27/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>	
23d. LOCATION (City, town or county) <i>Glen Burnie, Md.</i>		23e. REC'D BY REGISTRAR <i>1 1966</i>	
24. FUNERAL DIRECTOR <i>Kirkley Funeral Home, Glen Burnie, Md.</i>		25. REGISTRAR'S SIGNATURE <i></i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





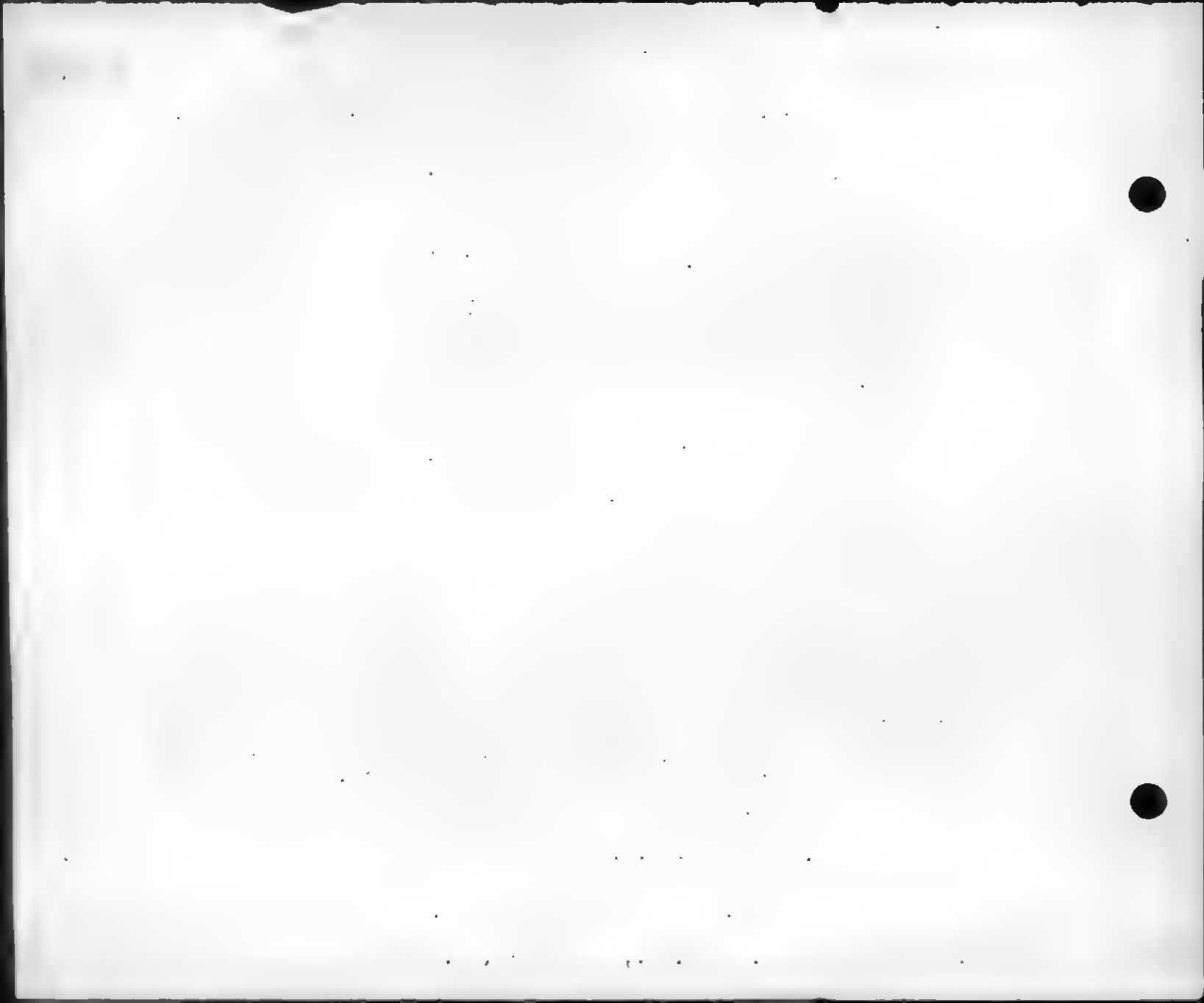
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00136 CERTIFICATE OF DEATH 00130

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Croftville</u> c. LENGTH OF STAY IN 1b <u>3 yrs, 7 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Croftville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>16000. Unknown</u> d. STREET ADDRESS <u>Unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>23718 Jalter Hill</u>		4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kent County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hill Hill</u>		14. MOTHER'S MAIDEN NAME <u>Nancy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Walter Hill</u>		Address <u>16000. Unknown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>General Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>In addition to above</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/25/62</u> , 19 <u>62</u> , to <u>1/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/11</u> , 19 <u>66</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter Hill, M.D.</u>		22d. ADDRESS <u>Croftville State Hospital, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/17/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>University of Md.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Walter Hill, M.D.</u>		25a. REC'D BY REGISTRAR <u>Walter Hill, M.D.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1  
FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

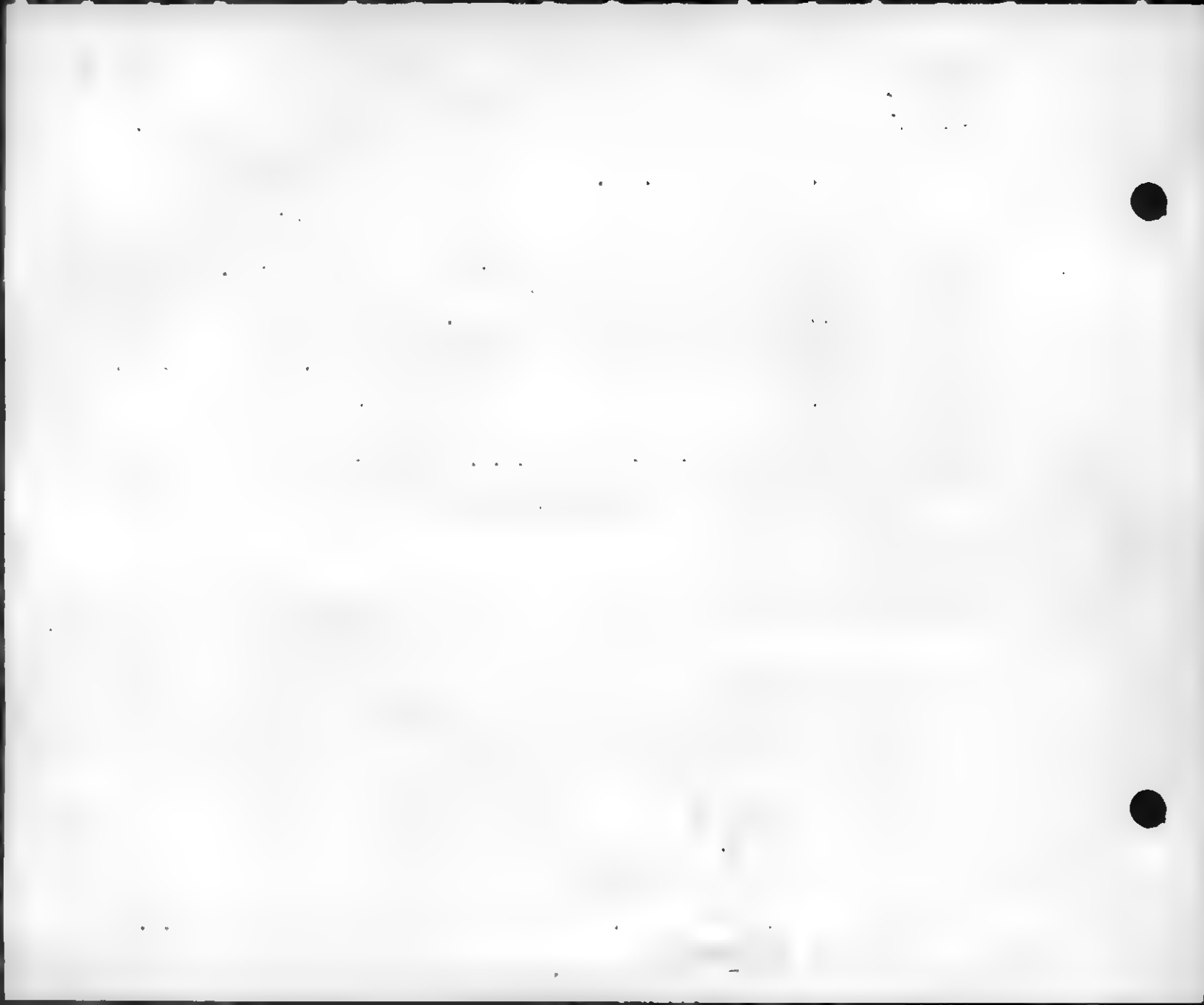
00137

00131

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Edgewater</u> d. STREET ADDRESS <u>Havre de Grace Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Warren Hudlow</u>		4. DATE OF DEATH Month Day Year <u>Jan. 22 1966</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 9, 1895</u>		9. AGE (in years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sheet metal worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing</u>				11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Mark Hudlow</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Mills</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-12-7049</u>				17. INFORMANT <u>Mrs. E. M. McLendon-sister</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. a. <u>Arteriosclerosis</u> b. <u>Arteriosclerosis</u> c. <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Arteriosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL EXAMINER'S NAME (Type) <u>K. L. Hopping</u>				M.O. <u>Chief Medical Examiner</u>				22. DATE SIGNED <u>1/22/66</u>				22. DATE SIGNED <u>1/22/66</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>1/24/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>							
24. FUNERAL DIRECTOR <u>Beverly E. Hopping</u> <u>Hopping Funeral Home</u> <u>Annapolis, Md.</u>								25. REC'D BY REGISTRAR <u>5 1966</u>				26. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

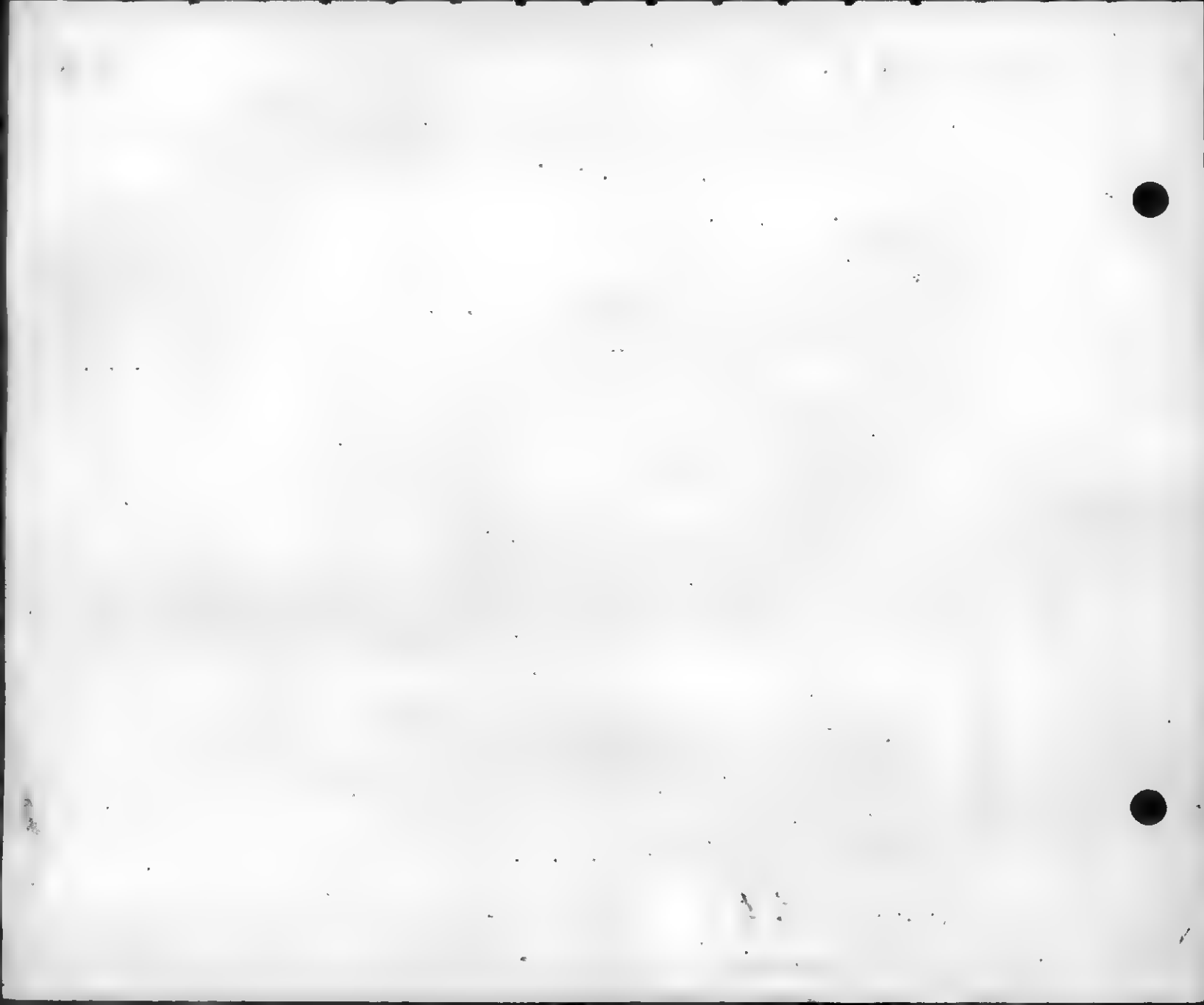
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00133

01682

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 15 yrs 4 mos. 22 days				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Baltimore City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital												e. STREET ADDRESS 7				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) 3-#12442 James				First Middle Last James Jeter				4. DATE OF DEATH Month 1 Day 27 Year 1966															
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED WIDOWED		NEVER MARRIED <input type="checkbox"/> UNKNOWN <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1891				9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Frank Jeter								14. MOTHER'S MAIDEN NAME Hilda															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerotic Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome due to Cerebral Arteriosclerosis																INTERVAL BETWEEN ONSET AND DEATH 3 days 16 days years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---				20f. (City or town) (County) (State) -----											
21. I certify that (I) (this hospital) attended the deceased from 9/5, 19 50 to 1/27, 19 66, that (I) (we) last saw the deceased alive on 1/27, 19 66, and that death occurred at 9:05, from the causes and on the date stated above.																							
22a. SIGNATURE <i>Lionel McHenry Mapp</i>												22b. DATE SIGNED 1/27/66											
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.												22d. ADDRESS Crownsville State Hospital, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-1-66				23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn				23d. LOCATION (City, town or county) (State) Baltimore Md											
24. FUNERAL DIRECTOR E. O. Wilson												25a. REC'D BY REGISTRAR 1000 Branly				25b. REGISTRAR'S SIGNATURE DATE Feb 9 1966							



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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00139

00132

1. PLACE OF DEATH a. COUNTY <b>ANCO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>A.A.Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA - March Brunel</b>				d. STREET ADDRESS <b>118 Appian Way</b>			
3. NAME OF DECEASED (Type or print) First <b>Winfield</b> Middle <b>G.</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26-18</b>	9. AGE (in years lost birthday) <b>48</b> yrs	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vending Mach. Technician Al Green Enterprises</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George R. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Lillian B. Gilbert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W W II</b>				16. SOCIAL SECURITY NO. <b>215-10-2423</b>		17. INFORMANT <b>Mrs. Hannah A. Johnson-118 Appian Way</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4344</b> <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. Linhart</b> M.D.				22. DATE SIGNED <b>1.31.66</b>			
EXAMINER'S NAME (Type) <b>E. Linhart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>2-4-1966</b>		<b>Baltimore National Cem.</b>		<b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce - 4001 Ritchie Hwy.</b>				25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Two p.v.u. - Film L 373 - 2/7/66 - MB



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00140

00133

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN It <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hosp.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Magothy Forge, Pasadena</b> d. STREET ADDRESS <b>02-1</b>		<b>3. NAME OF DECEASED</b> (Type or print) <b>Dorathy Annette Johnston</b> First Middle Last <b>5. SEX</b> <b>F</b> <b>6. COLOR OR RACE</b> <b>W</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>May 9, 1918</b> <b>9. AGE</b> (In years last birthday) <b>47</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Chem. Co.</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <b>William Eaton</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Annette Giesler</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>217 09 6881</b> <b>17. INFORMANT</b> <b>Mr. Robert Rousset</b> Address <b>Annapolis, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>mesenteric thrombosis - inferior</b> <b>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.</b> <b>mesenteric vessels</b> <b>DUE TO (c)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 days</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Gastric ulcer</b>		<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from 1/11/1966 to 1/22/1966, that (I) (we) last saw the deceased alive on 1/22/1966, and that death occurred at 8:00 p.m. from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>S. Borssuck</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>S. Borssuck</b>		<b>22b. DATE SIGNED</b> <b>1/22/1966</b> <b>22d. ADDRESS</b> <b>Richard Henry, Glen Burnie Md</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/26/66</b>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cem.</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>JOHN F. DENNY, INC. 715 Light St.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>JAN 26 1966</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

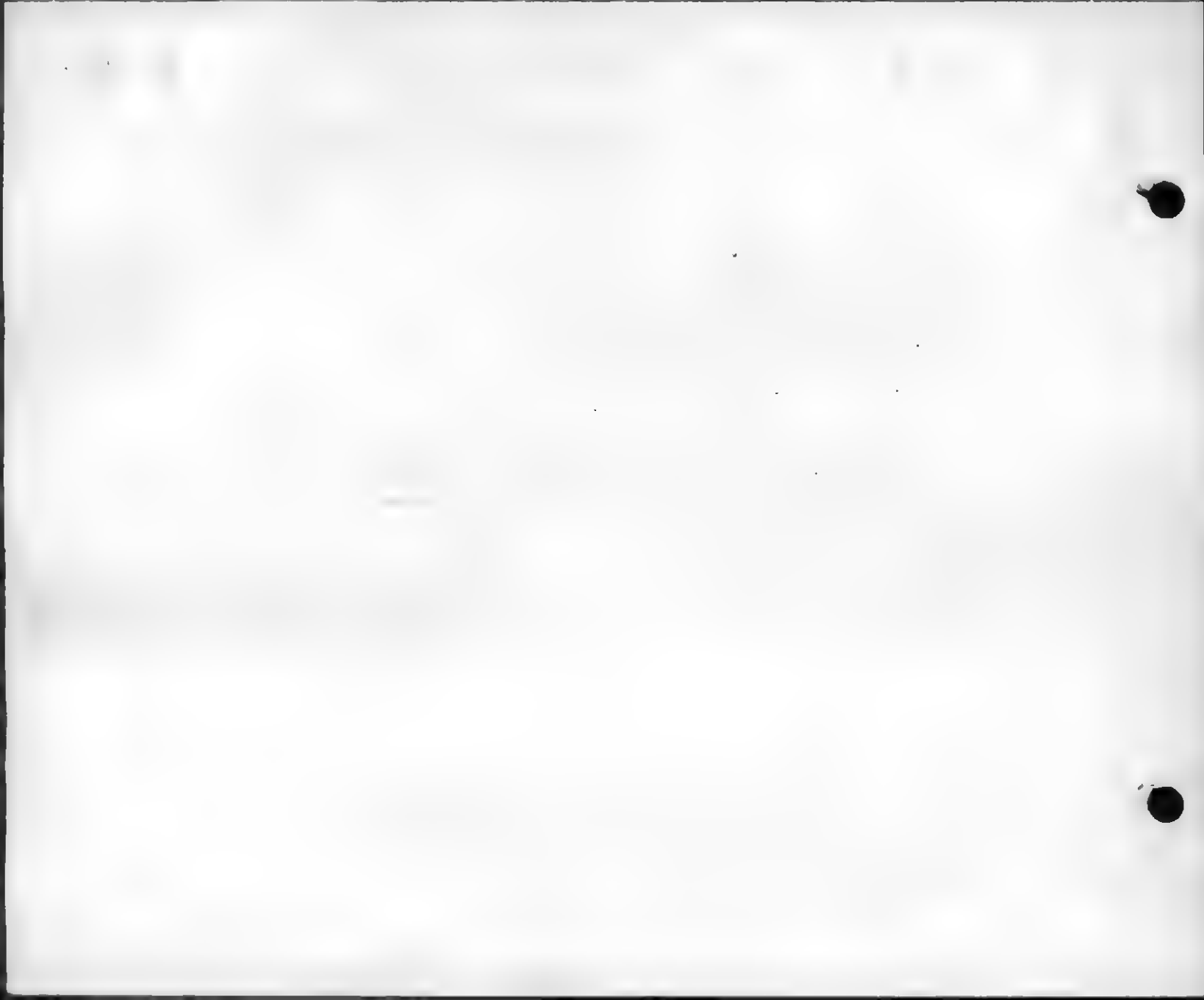
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 FOR STATE HEALTH DEPT

00141

00134

1. PLACE OF DEATH a. COUNTY <i>Ch. Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Ch. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Annapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Archie General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Arthur</i> Middle <i>B</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>1</i> Day <i>5</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-11-1914</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Helper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Radio Station</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Arthur B Jones Sr.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		14. MOTHER'S MAIDEN NAME <i>Sarah Hillary</i>	
16. SOCIAL SECURITY NO. <i>Marie S Jones</i>		17. INFORMANT <i>5 Roosevelt Dr</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500 pneumonia pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i>		22. DATE SIGNED <i>1/5/66</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>St. Margarets Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1-9-1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>	23d. LOCATION (City, town or county) (State) <i>St. Margarets Md.</i>
24. FUNERAL DIRECTOR <i>William Beesett</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 6 1966</i>	
ADDRESS <i>Annapolis Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

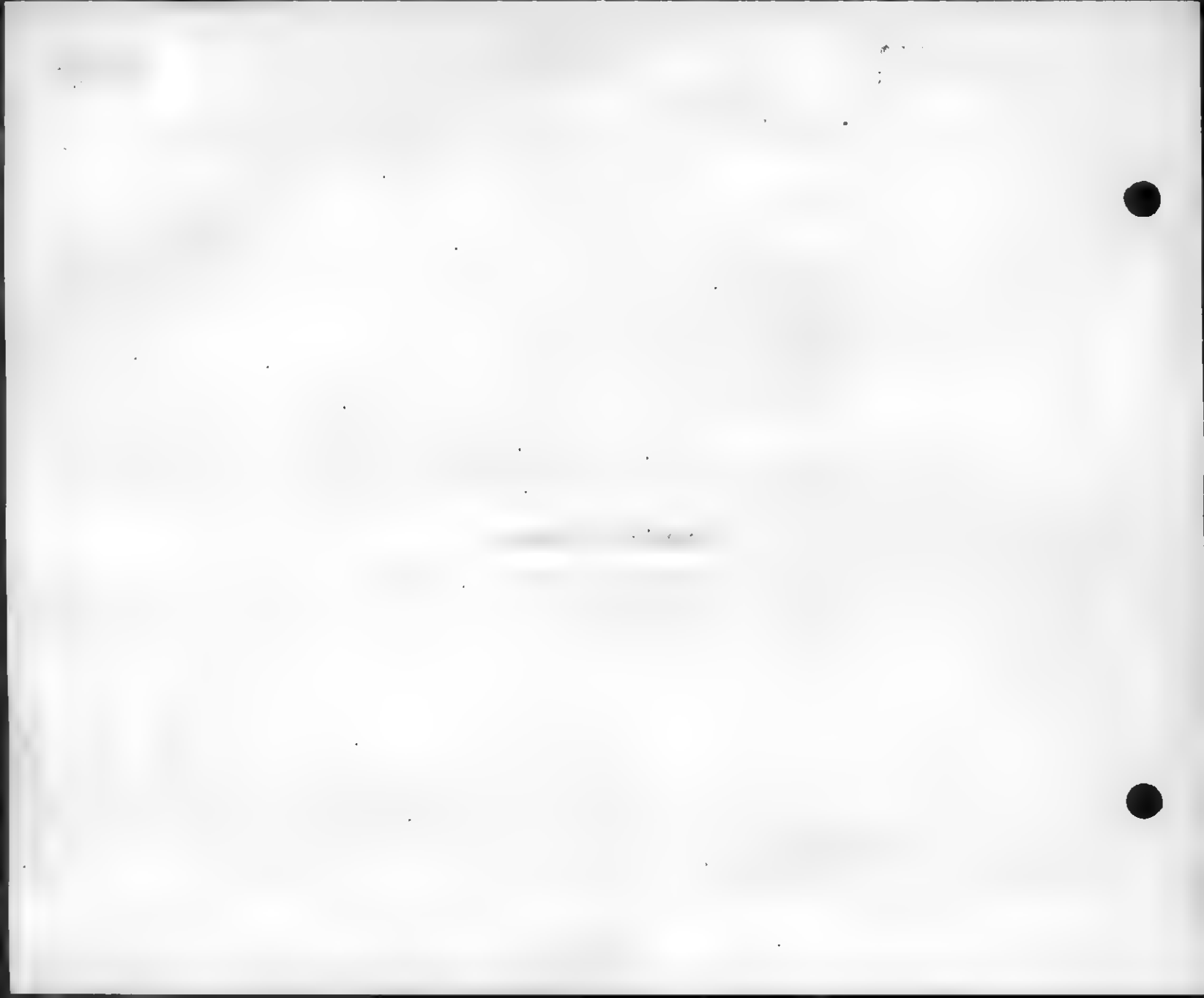


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.~~

VR A15 (4)  
15M 4-64

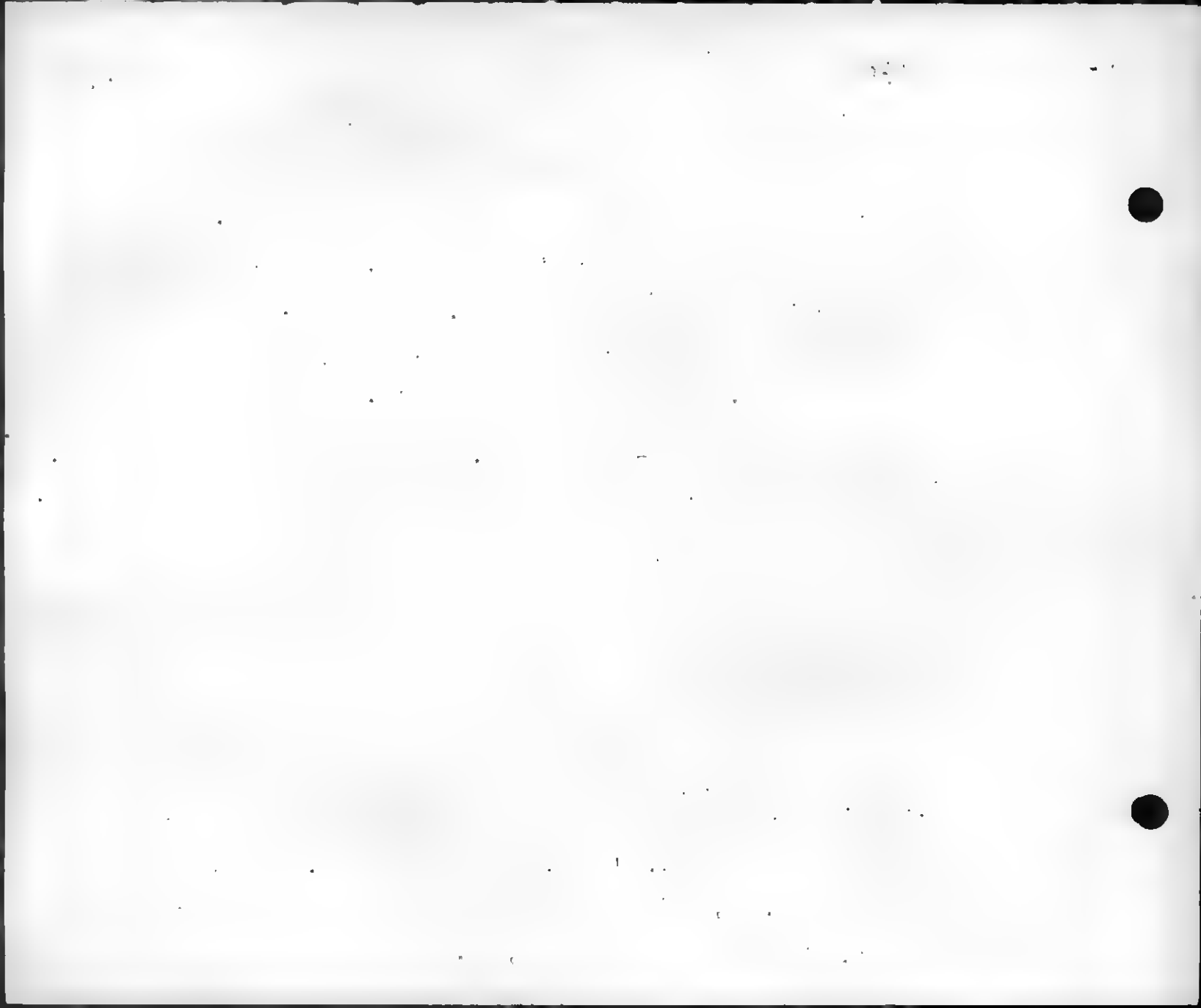
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00142 Item #8 Film #1513-1/24/66 00135											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN ID <u>27 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Children's Center Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>R.</u> Last <u>Kehoe</u>			4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1966</u>								
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/98</u> 97		9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Institutionalized</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Children's Center Hospital, Laurel, Md.</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Mental retardation - moderate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>39</u> , to <u>1/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> , 19 <u>66</u> , and that death occurred at <u>8:05</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Margaret W. Mola</u>					22b. DATE SIGNED <u>1/18/66</u>						
22c. PHYSICIAN'S NAME (Type) <u>Margaret W. Mola, M. D.</u>			22d. ADDRESS <u>Children's Center Hospital, Laurel, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST CHARLES CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>Glymouth, Maryland</u>					
24. FUNERAL DIRECTOR <u>W. W. Chambers Co. Inc. 517 11th St SE Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John Jay Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>00143</b> 1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b> <b>7 DAYS</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>NORTH ARUNDEL GENERAL HOSPITAL</b>					<b>00136</b> 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>ANNE ARUNDEL</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE</b> d. STREET ADDRESS <b>BOX 363A BROOKWOOD RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WESLEY</b> Last <b>KELLER, SR.</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>18</b> Year <b>1966</b>				
5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>DEC. 17, 1901</b> 9. AGE (in years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>					10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPYARD</b> 11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>GEORGE H. KELLER</b>					14. MOTHER'S MAIDEN NAME <b>MARY J. RUBY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>None</b>					16. SOCIAL SECURITY NO. <b>213-09-4677</b> 17. INFORMANT <b>MRS. IONA KELLER</b> Address <b>MILLERSVILLE, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 3024 DUE TO (b) <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Embolism</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. <b>19</b> Month, Day, Year p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6</b> , 19 <b>63</b> , to <b>Jan</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Hilary T. O'Herilhy</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>1/18/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>HILARY T. O'HERILHY</b>					22d. ADDRESS <b>5 CENTRAL AVE. GLEN BURNIE, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan. 21, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk. Glen Burnie, Maryland</b>			23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Richard V. Singleton</b> ADDRESS <b>Glen Burnie, Md.</b>					25a. REC'D BY REGISTRAR <b>JAN 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Samuel Judge</b>		

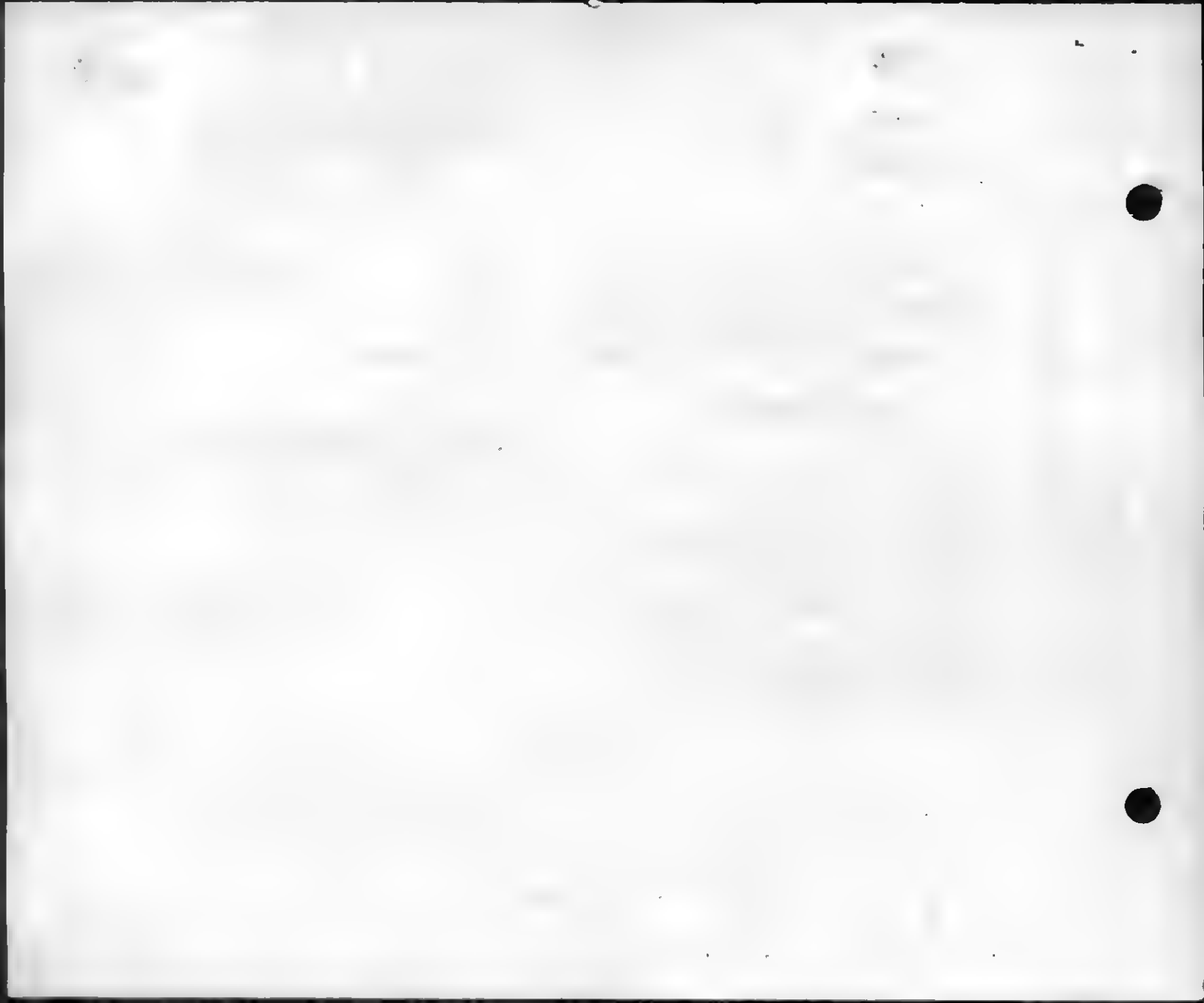




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>ANNAPOLIS</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>214 DEWEY DRIVE</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3505 CLARKS LANE APT A2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>(GORELIK)</u> Last <u>KRUGER</u>						4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1966</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/1/1890</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>ISRAEL EHERNBERG</u>						14. MOTHER'S MATEOEN NAME <u>FAIZA ?</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. BERNARD BECKER</u> Address <u>3505 CLARKS LANE APT A2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4200</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Chapman</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>11/16, 1965</u> to <u>1/27, 1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1/26, 1966</u> , and that death occurred at <u>2:50</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>Richard I. Hochman</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/27/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>						22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OHR KNESSETH ISRAEL ANSHE SFARD</u>				23d. LOCATION (City, town or county) (State) <u>ROSEDALE, MARYLAND</u>					
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC.</u> ADDRESS <u>6010 REISTERSTOWN RD</u>						25a. REC'D BY REGISTRAR <u>FEB 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>las Judge</u>					



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

00145

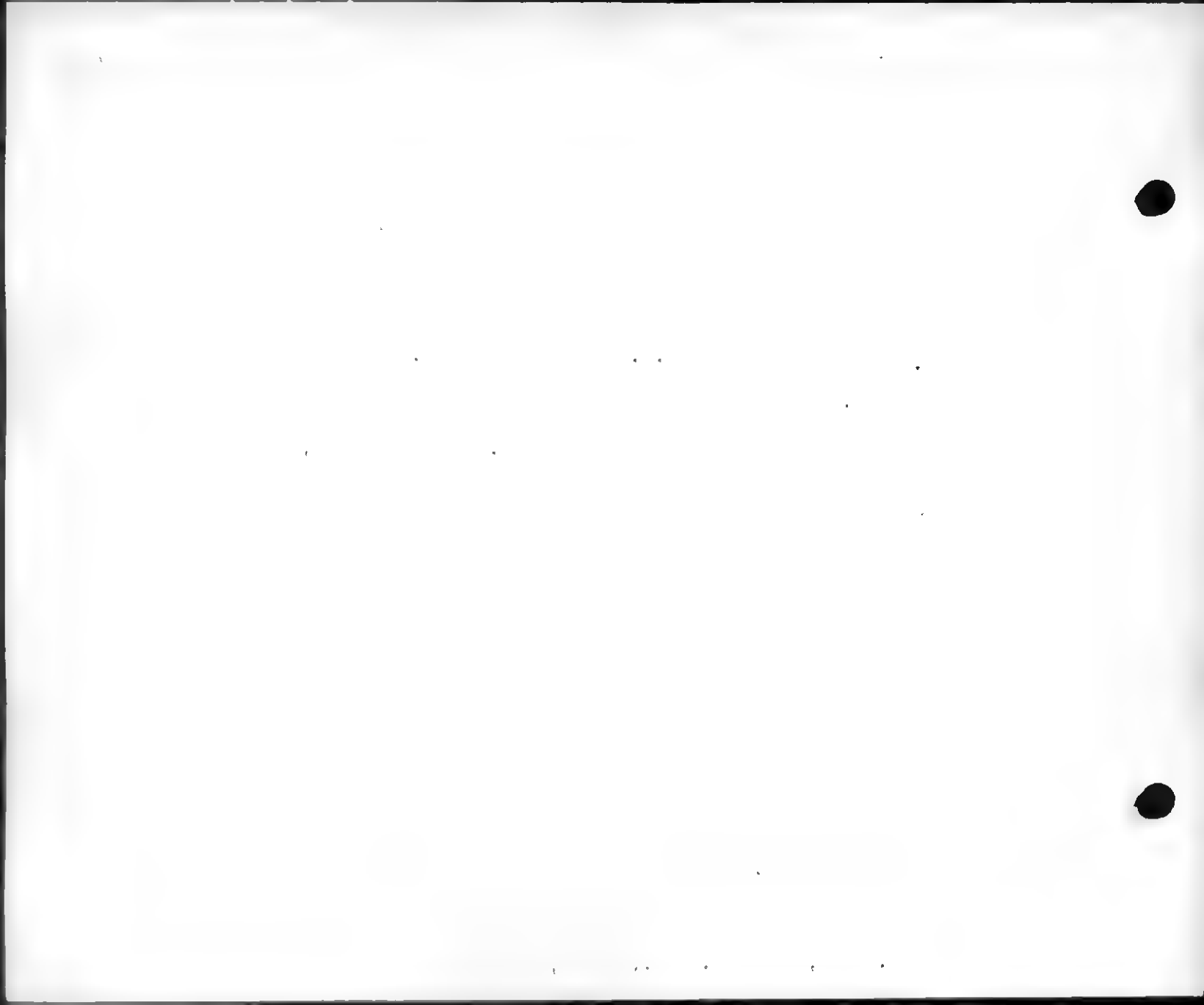
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00138

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used for burial, cremation, or removal, and in any event within 72 hours after death. Health or its designated agent, prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY <b>RAALCO.</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>GLEN BURNIE</b> c. LENGTH OF STAY IN TB <b>366 MAR Rd. - Glen Burnie</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>RAALCO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b> d. STREET ADDRESS <b>366 MAR Rd. - Glen Burnie</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>CLAUDE</b> Middle <b>A</b> Last <b>LEDWELL</b>		4 DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>1966</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>APR. 8 - 1919</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLD</b>		10b KIND OF BUSINESS OR <b>U.S. ARMY</b>	11 BIRTHPLACE (State or foreign country) <b>North Carolina</b>
13 FATHER'S NAME <b>Nathan Ledwell</b>		14 MOTHER'S MAIDEN NAME <b>Ella (deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17 INFORMANT Address <b>Mrs. Evelyn Ledwell, same as #2</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute Suppurative Edema</b> DUE TO <b>aspiration of the contents</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>aspiration of the contents</b> (c) <b>aspiration of the contents</b>			INTERVAL BETWEEN ONSET AND DEATH <b>burden</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. L. H. H. H.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>1-11-66</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>Jan 12, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>MOORE FAMILY CEMETERY</b>	23d LOCATION (City or Town) (County) (State) <b>TURKEY, NORTH CAROLINA</b>
24 FUNERAL DIRECTOR <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 17 1966</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR AIS (4)  
20M 1/65

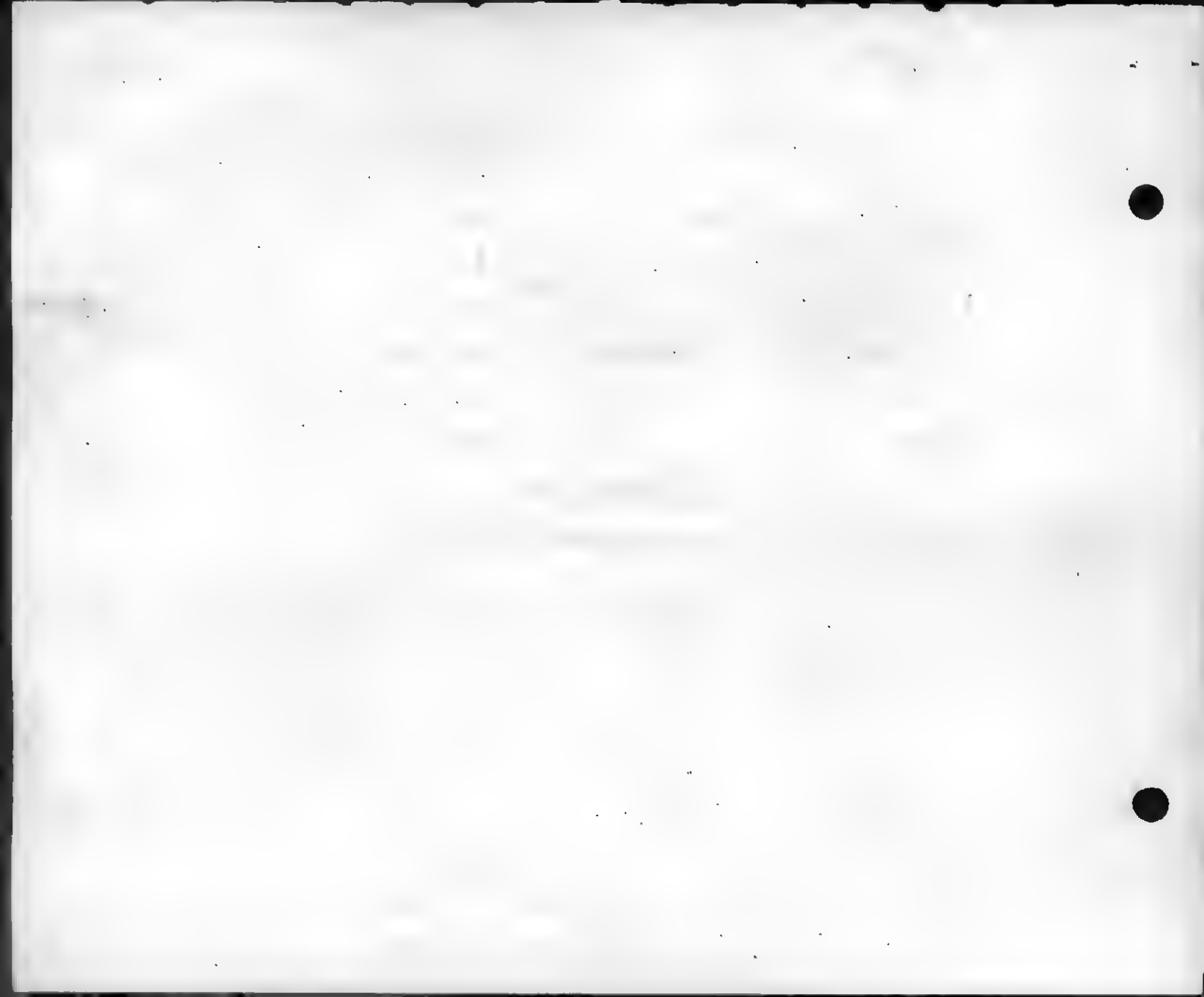
00146

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00139

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>113 Fernside Ave, (Fernside)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>				e. STREET ADDRESS <u>Glen Burnie</u>			
3. NAME OF DECEASED (Type or print) <u>"Baby Girl" Shirley Ann Lee</u>				4. DATE OF DEATH Jan. 12 1966			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/66</u>	
9. AGE (in years last birthday) <u>10</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co. - Md.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Homer Lee</u>			
14. MOTHER'S MAIDEN NAME <u>Margie Blanton</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs Margie Lee</u> Address <u>113 Fernside Ave, Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATUREITY</u> <u>7615</u> DUE TO (b) <u>HEMORRHAGIC CAPUT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1-725</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>GLEN BURNIE AA Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12 Jan</u> 19 <u>66</u> , to <u>12 Jan</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12 Jan</u> 19 <u>66</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Shirley Ann Lee</u> M.D.				22b. DATE SIGNED <u>12 Jan 66</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>Jan. 15/66</u>		<u>Glen Haven Mem. Park</u>		<u>Glen Burnie, Md</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>17 Jan 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>J. J. ...</u>							

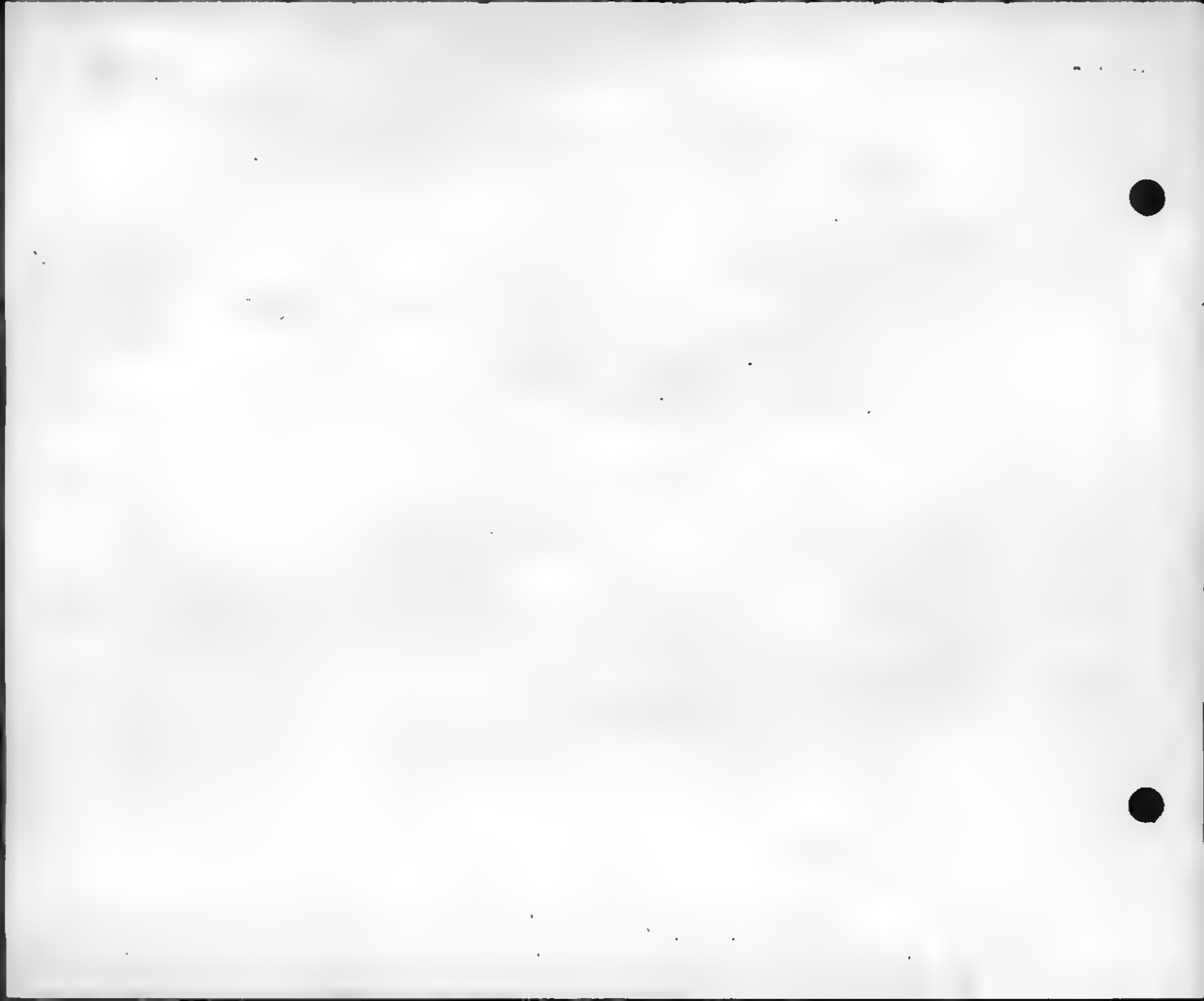
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00147 CERTIFICATE OF DEATH 00140											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 27					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>						d. STREET ADDRESS <u>2725 Alderwood Ave</u>					
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>J</u> Last <u>Lehtinen</u>						4. DATE OF DEATH Month <u>Jan</u> Day <u>2nd</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/82</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical (at)</u>				10b. KIND OF BUSINESS, OR INDUSTRY <u>Shipbuilding</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Andrew Lehtinen</u>						14. MOTHER'S MAIDEN NAME <u>Maria Rissanen</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Hospital Chart.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3rd Dec.</u> 19 <u>65</u> , to <u>2nd Jan</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2nd Jan</u> 19 <u>66</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Alvin Thompson</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/2/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Alvin Thompson</u>						22d. ADDRESS <u>Crownsville State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>1-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Thonbonne, MD</u>					
24. FUNERAL DIRECTOR <u>Samuel J. Simpson</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



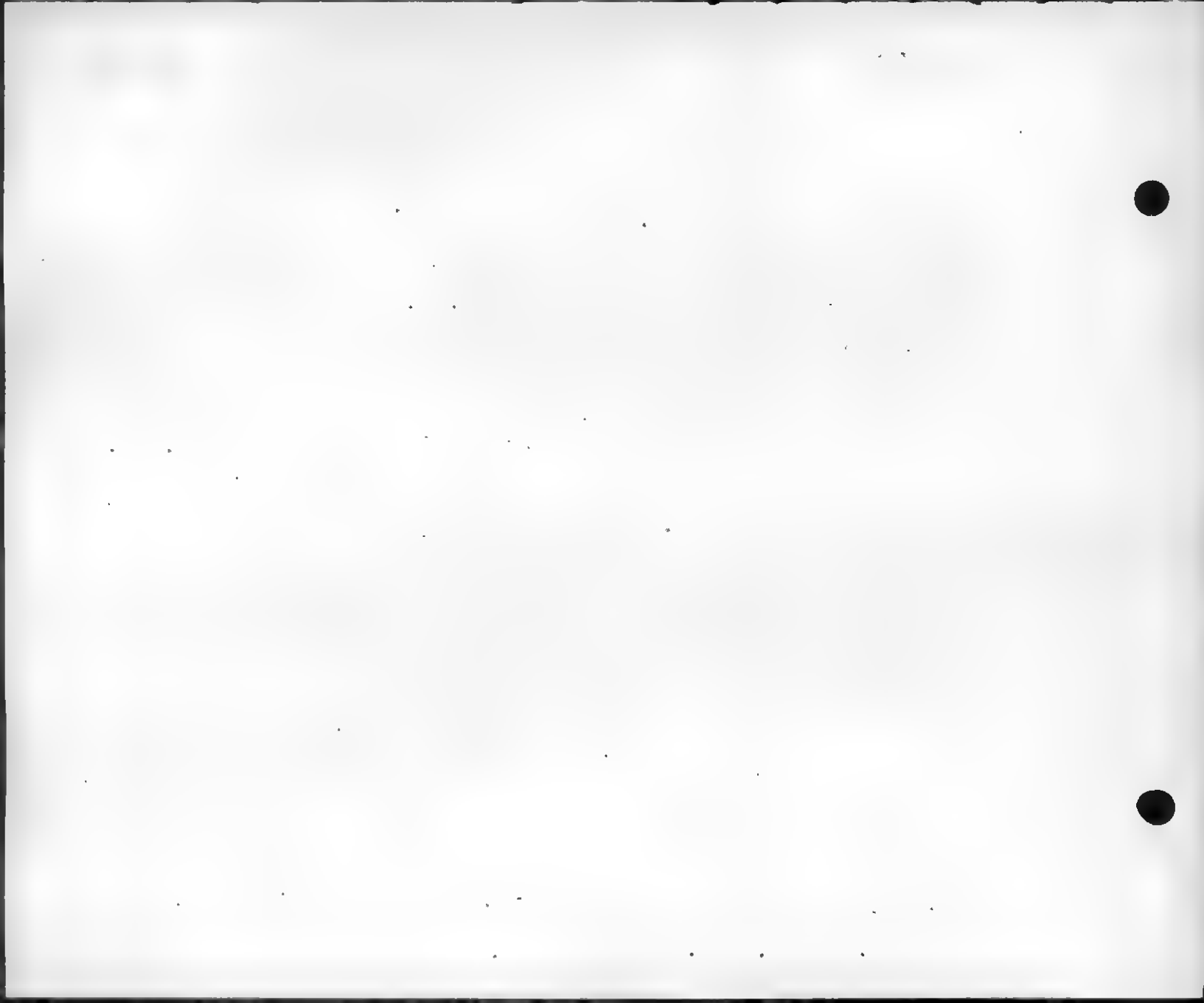


## CERTIFICATE OF DEATH

00148

00341

1. PLACE OF DEATH a. CDUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Scioto</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS	
<u>NORTH ARUNDEL HOSPITAL</u>		<u>Sciotoville Rt. 2</u>	
3. NAME OF DECEASED (Type or print) <u>MARY MARIE Lilly</u>		4. DATE OF DEATH <u>JANUARY 15 1966</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 4, 1897</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>James Lilly</u>		Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Postoperative venous thrombosis</u> DUE TO (c) <u>Hip operation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min 4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic and arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>12/20</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>12/20</u>		20f. (City or town) <u>Scioto</u> (County) <u>Scioto</u> (State) <u>Ohio</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>65</u> to <u>1/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> , 19 <u>66</u> , and that death occurred at <u>6</u> M., from the causes and on the date stated above		22a. SIGNATURE <u>James Lilly</u> 22b. DATE SIGNED <u>1/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. VASH</u>		22d. ADDRESS <u>206, S. S. M. or St. Beet 23</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bennett Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Minford, Ohio</u>	
24. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC. 715 Light St.</u>		25a. REC'D BY REGISTRAR <u>JAN 19 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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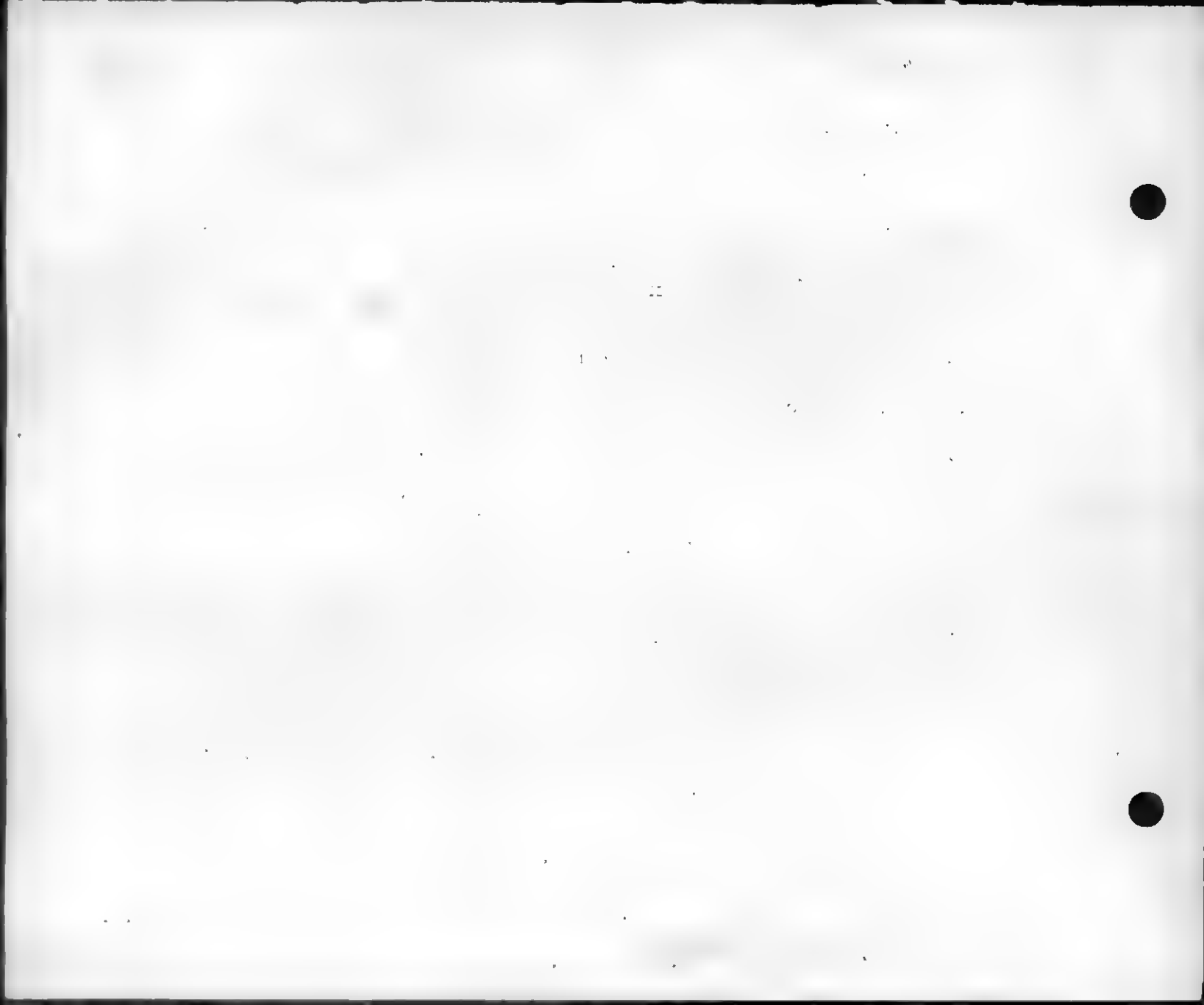
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00149

00142

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Edgewater</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Edgewater</u> C-1		
c. LENGTH OF STAY IN 1b <u>12 years</u>			d. STREET ADDRESS <u>Route 2, Box 4, Edgewater</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2, Box 4, Edgewater</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elton Forrest LOLLO</u>			4. DATE OF DEATH Month Day Year <u>January 19, 1966</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept. 15, 1899</u>		9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement, Defense</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Williamstown, N. J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Martin M. Lollo</u>		14. MOTHER'S MAIDEN NAME <u>Effie Morgan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(wife) Frances Miriam Lollo, same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>2001</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastrointestinal hemorrhage</u> DUE TO (c) <u>Lymphosarcoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>10 min.</u> <u>2 years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Auricular fibrillation</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 3, 1964</u> , to <u>Jan. 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 19, 1966</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Charles W. Kinzer</u>				22b. DATE SIGNED <u>Jan. 19, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>				22d. ADDRESS <u>So. River Med. Cent., Edgewater, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	
23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>					
24. FUNERAL DIRECTOR <u>Burial &amp; Hopping</u>		ADDRESS <u>HOPPING FUNERAL HOME Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>1966</u>	
25b. REGISTRAR'S SIGNATURE <u>George</u>					



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ANNE ARUNDEL</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <b>3 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>200 Clay Street</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>ANNE ARUNDEL</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>24 Lafayette Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>MAGGIE CECIL PINKNEY LONG</b> First Middle Last <b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>Negro</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Nov. 1-1898</b> <b>9. AGE</b> (In years last birthday) <b>67</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>A.A.Co. Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John Wesley Pinkney</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>217-30-4890</b>		<b>17. INFORMANT</b> <b>Hattie G. Holland-200 Clay St. Anna. Md.</b> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Auto Exhaust Arrest</b> <b>4330 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <b>DUE TO (c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 M</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 11-10-52, 19 to 1-10-66, 19, that (I) (we) last saw the deceased alive on 11-10-65, 19, and that death occurred at M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>A.T. Allen</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>A.T. Allen</b>		<b>22b. DATE SIGNED</b> <b>1-10-66</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>M.D.</b> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>Cathedral St. Annapolis, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Jan. 12-66</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Brewer Hill</b> <b>23d. LOCATION (City, town or county)</b> (State) <b>Annapolis, Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>C.E. Hicks 111 Annapolis, Md.</b> ADDRESS		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 17 1966</b> DATE <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR /15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <div style="text-align: center;">Anne Arundel</div>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <div style="text-align: center;">Maryland</div>				
<b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Crownsville</div>					<b>c. LENGTH OF STAY IN 1b</b> <div style="text-align: center;">1 yr. 6 mos. 15 days</div>				
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <div style="text-align: center;">Crownsville State Hospital</div>					<b>d. STREET ADDRESS</b> <div style="text-align: center;">100000 Baltimore Ave.</div>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>First</b> <b>Middle</b> <b>Last</b> <div style="text-align: center;">3-#27682 Idella E. Lowman</div>					<b>4. DATE OF DEATH</b> <div style="text-align: center;">Month 1 Day 24 Year 19 66</div>				
<b>5. SEX</b> <div style="text-align: center;">Female</div>		<b>6. COLOR OR RACE</b> <div style="text-align: center;">White</div>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <div style="text-align: center;">August 7, 1908</div>		<b>9. AGE</b> (In years last birthday) <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> <div style="text-align: center;">87 yrs. Months Days Hours Min.</div>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Housewife</div>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center;">---</div>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <div style="text-align: center;">Maryland</div>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="text-align: center;">U.S.A.</div>	
<b>13. FATHER'S NAME</b> <div style="text-align: center;">Unknown Richard Lowman</div>					<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center;">Unknown Caroline Hammond</div>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center;">No</div>					<b>16. SOCIAL SECURITY NO.</b> <div style="text-align: center;">215-12-3397</div>				
<b>17. INFORMANT</b> <div style="text-align: center;">Hospital Records</div>					<b>Address</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <div style="text-align: center;">4221 Arteriosclerotic Cardiovascular Disease</div> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <div style="text-align: center;">(b) DUE TO</div> <div style="text-align: center;">(c) DUE TO</div>									<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>									<b>19. WAS AUTOPSY PERFORMED?</b> <div style="text-align: center;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center;">-----</div>				
<b>20c. TIME OF INJURY</b> Month, Day, Year <div style="text-align: center;">Hour a.m. --- p.m. 19</div>			<b>20d. INJURY OCCURRED</b> <div style="text-align: center;">White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></div>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <div style="text-align: center;">-----</div>		<b>20f. (City or town) (County) (State)</b> <div style="text-align: center;">-----</div>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <div style="text-align: center;">7/9</div> , 19 <div style="text-align: center;">64</div> to <div style="text-align: center;">1/24</div> , 19 <div style="text-align: center;">66</div> , that (I) (we) last saw the deceased alive on <div style="text-align: center;">1/24</div> , 19 <div style="text-align: center;">66</div> , and that death occurred at <div style="text-align: center;">4P</div> M, from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <div style="text-align: center;">Hildegard Heard Reissmann</div>					<b>22b. DATE SIGNED</b> <div style="text-align: center;">1/24/66</div>		<b>22c. PHYSICIAN'S NAME</b> (Type) <div style="text-align: center;">Hildegard Heard Reissmann, M.D.</div>		
<b>22d. ADDRESS</b> <div style="text-align: center;">Crownsville State Hospital, Md.</div>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <div style="text-align: center;">Burial</div>			<b>23b. DATE THEREOF</b> <div style="text-align: center;">1/27/66</div>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center;">Nichols Memorial</div>		<b>23d. LOCATION</b> (City, town or county) (State) <div style="text-align: center;">Odenton Md</div>		
<b>24. FUNERAL DIRECTOR</b> <div style="text-align: center;">Hopling Funeral Home - Annapolis, Md.</div>					<b>25a. REC'D BY REGISTRAR</b> <div style="text-align: center;">JAN 26 1966</div>		<b>25b. REGISTRAR'S SIGNATURE</b> <div style="text-align: center;">Charles Judge</div>		

MEDICAL CERTIFICATION

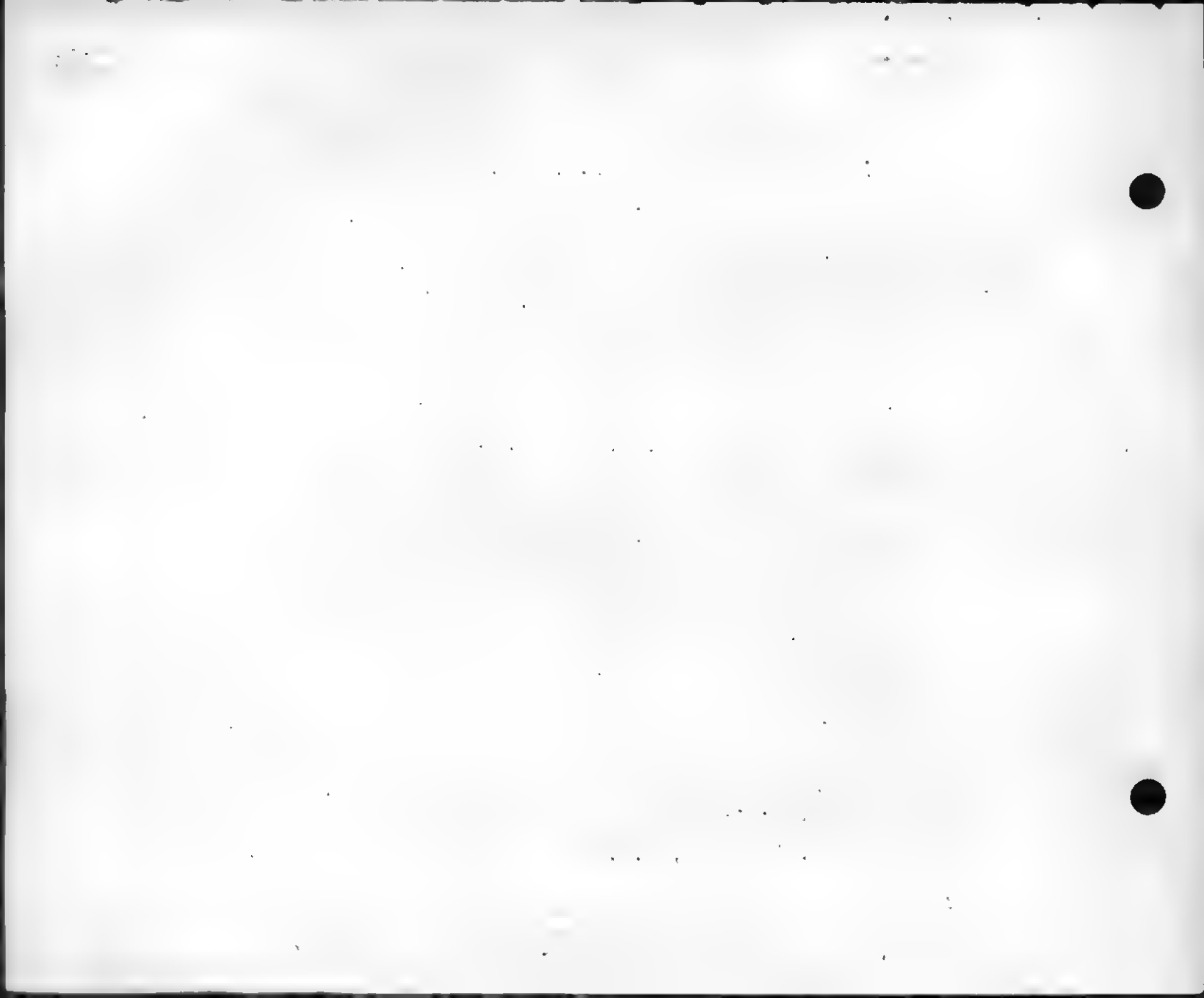




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00152 Item #9 Film #0372 1/28/66 00145											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel County				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 7 mos. 16 days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 2126 Jefferson St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) #29594 George Grover Marion				4. DATE OF DEATH Month 1 Day 16 Year 19 56							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/24		9. AGE (in years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Marion				14. MOTHER'S MAIDEN NAME Margaret							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 094-18-2487		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Alcoholism (Addiction)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Crownsville, Maryland			
21. I certify that (I) (this hospital) attended the deceased from 5/25, 1955, to 1/15/1956, that (I) (we) last saw the deceased alive on 1/16/1956, and that death occurred at 3:20 PM, from the causes and on the date stated above.											
22a. SIGNATURE L. Benedict, M.D.				22b. DATE SIGNED 1/21/66							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Crownsville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-24-66		23c. NAME OF CEMETERY OR CREMATORY Charmington-Med.		23d. LOCATION (City, town or county) (State) Baltimore Md.					
24. FUNERAL DIRECTOR Wm Reese II 108 W Washington St				25a. REC'D BY REGISTRAR DATE 1-24-66		25b. REGISTRAR'S SIGNATURE					



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00153

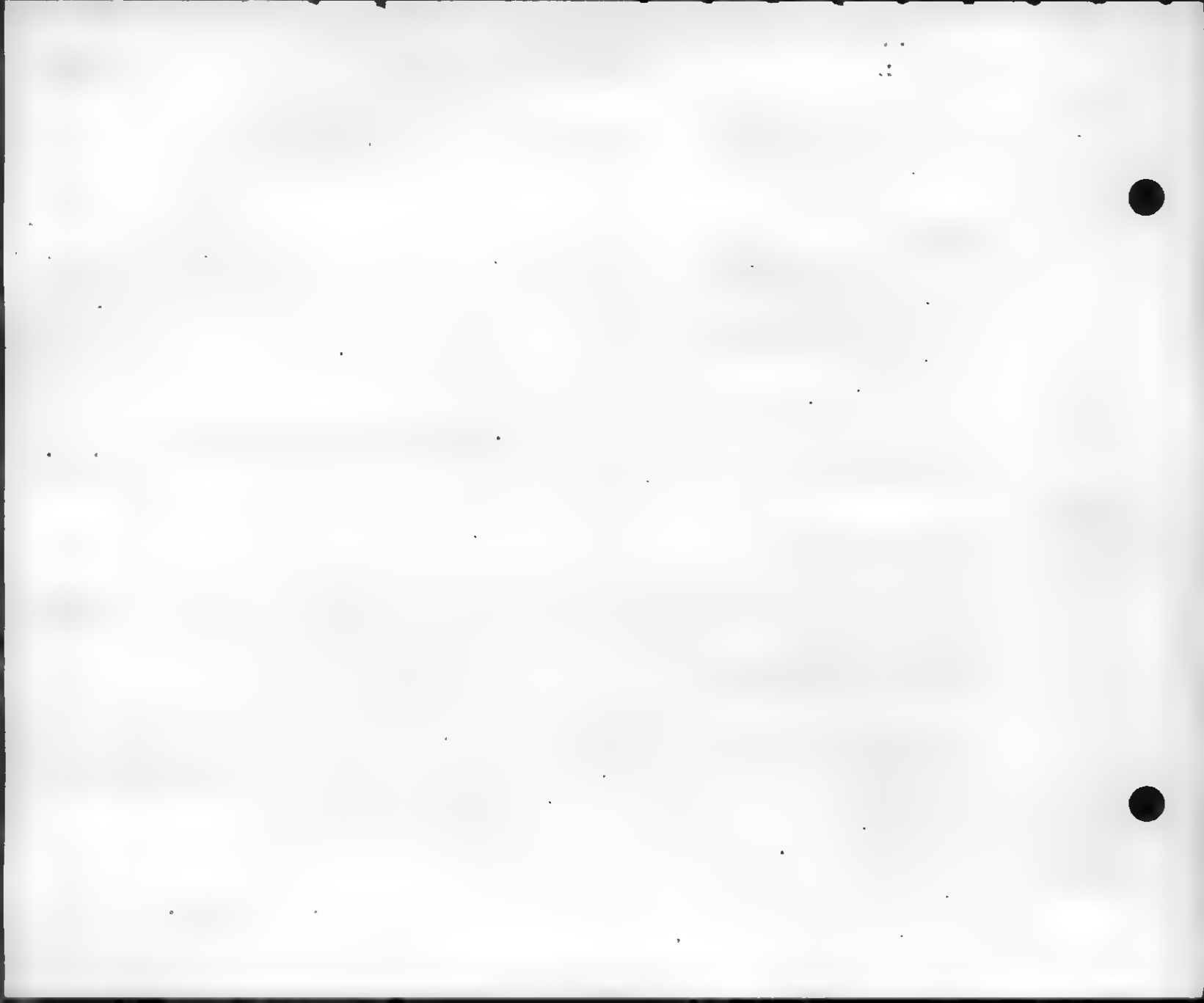
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00146

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN ID		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE		b. COUNTY	
ANNE ARUNDEL		MARYLAND		11 hours		MARYLAND		ANNE ARUNDEL	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
NORTH ARUNDEL GENERAL HOSPITAL		RT 1 BOX 134							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
DIONIGI				MARROCCO		MARROCCO		JANUARY 6 1966	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		OCTOBER 9, 1889		76 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
CONTRACTOR		GENERAL CONTRACTING		ITALY		UNITED STATES			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
FRANK MARROCCO		ROSE VOLPE		NO		218-32-2049		Mrs. Rose Taylor 5937 Kaven Avenue, #6 MRS LOUIS PFARR RT 16 BOX 476 BALTO., MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		DUE TO		DUE TO	
4201		Coronary occlusion		Coronary atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)				7RS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that (I) (this hospital) attended the deceased from 1-5, 1966, to 1-6, 1966, that (I) (we) last saw the deceased alive on 1-6, 1966, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
		E. Ernest A. Leipold				Dr. Leipold			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		1/8/66		Holy Redeemer Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Schimmunek Funeral Home, Inc.		DATE JAN 10 1966		J. J. Judge					
3331 Brehms Lane #13									



1  
FOR STATE  
HEALTH DEPT.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00154

00147

1. PLACE OF DEATH  
a. COUNTY A. A. MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 50 Shan St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Md. b. COUNTY Anne Arundel  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis  
d. STREET ADDRESS 50 Shan St.  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Mary Ruth Matthews  
First Middle Last  
4. DATE OF DEATH 1-13-1966  
Month Day Year

5. SEX Female 6. COLOR OR RACE Col 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-20-1914  
WIDOWED ☒ DIVORCED ☐ 9. AGE (In years, last birthday) 51 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Md 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Simpson 14. MOTHER'S MAIDEN NAME Margaret Simpson  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 215-34-1198 17. INFORMANT William S. Simpson - Annapolis, Md  
Address 215-34-1198

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 443X DUE TO Myocardial Infarction  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) None  
(c) None  
INTERVAL BETWEEN ONSET AND DEATH None

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day Year 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State)

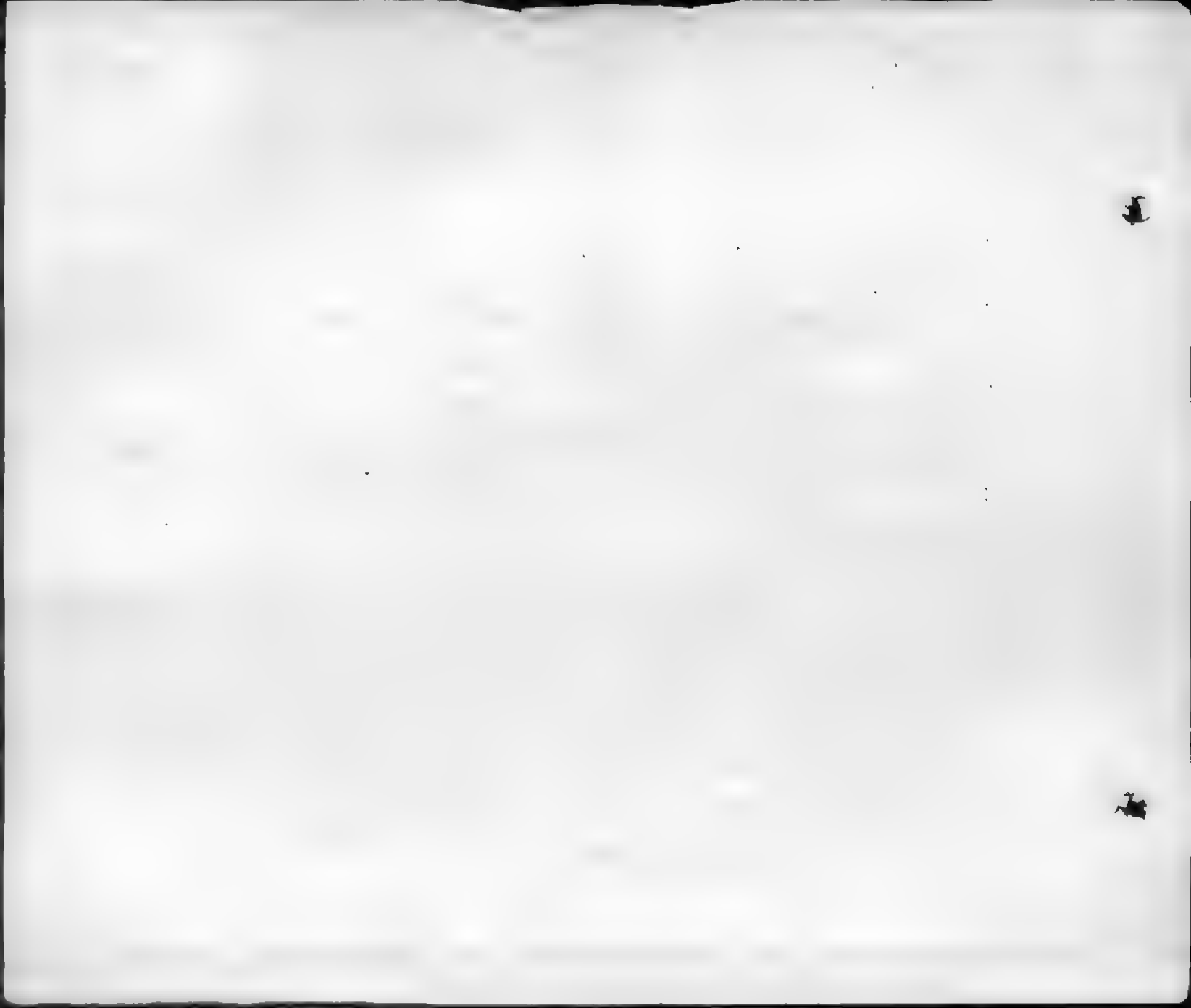
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (Type) E. L. H. [Signature]  
M D  
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☒  
Address (Street, city, town, or county) 1-13-66

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1-17-1966 22c. NAME OF CEMETERY OR CREMATORY Brewer Hall 22d. LOCATION (City, town, or county) (State) Annapolis Md

23. FUNERAL DIRECTOR William Reese # ADDRESS Annapolis Md 24a. REC'D BY REGISTRAR J. Charles Judge 24b. REGISTRAR'S SIGNATURE J. Charles Judge  
DATE JAN 17 1966

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

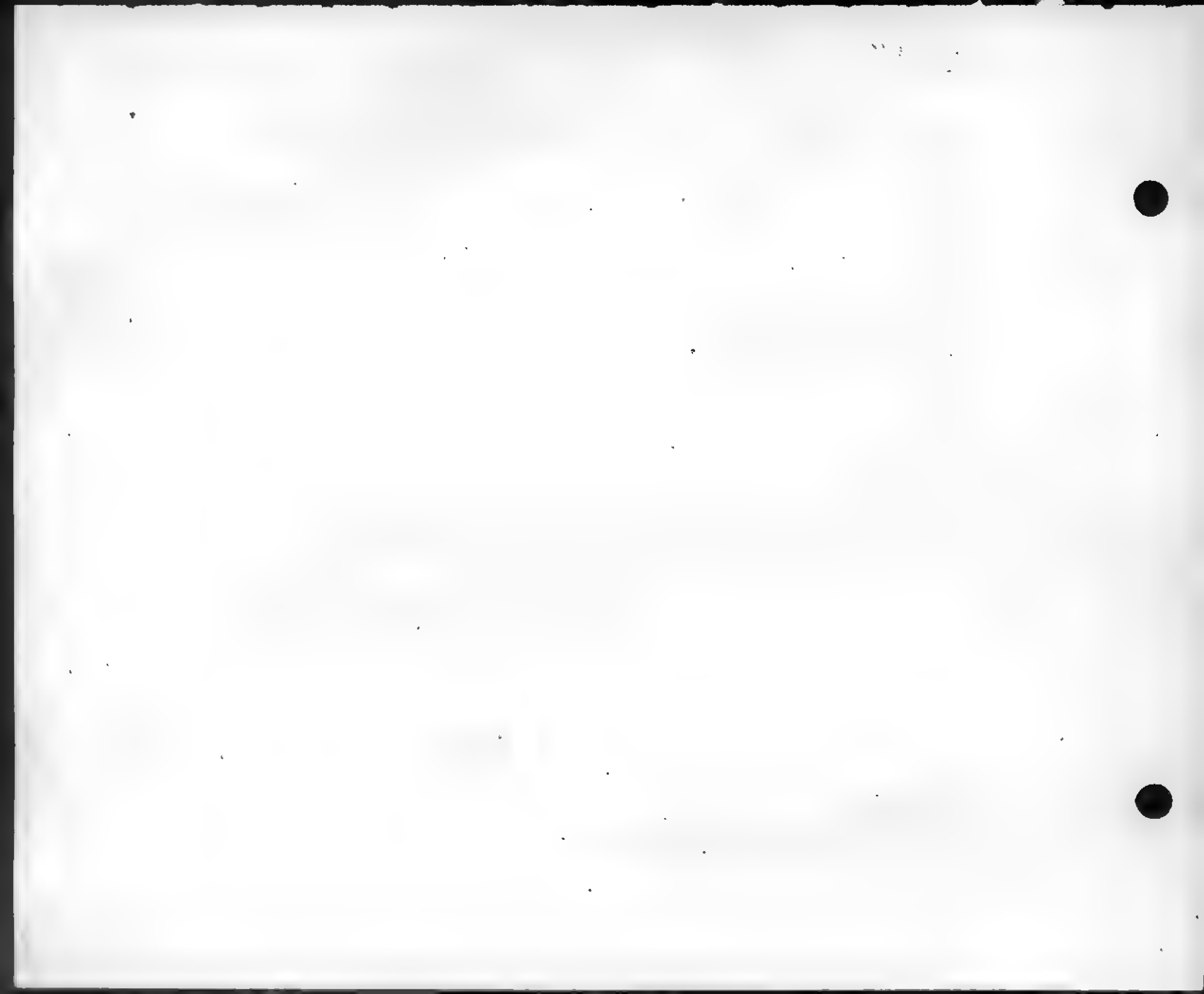


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

54

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																				
<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>NORTH ARUNDEL GEN HOSPITAL</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> d. STREET ADDRESS <u>Rt 5 Box 207 Mountain Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) <u>ASEY</u> First Middle Last <u>MATTHEWS</u>			<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>27</u> Year <u>1966</u>			<b>5. SEX</b> <u>MALE</u>			<b>6. COLOR OR RACE</b> <u>COLORED</u>			<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>July 15 1895</u>			<b>9. AGE</b> (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FERTILIZER CO.</u>						<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>A.A. CO MD</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>														
<b>13. FATHER'S NAME</b> <u>JOHN MATTHEWS</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>JANE DORSEY</u>														
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>218-09-1982</u>			<b>17. INFORMANT</b> <u>ROLA TURNER - PASADENA MD</u>			Address											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>4201</u> DUE TO (b) <u>Hypertensive Cardiorenal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u>								
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>						
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)														
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 10, 1963</u> <b>to</b> <u>1-27, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>1-22, 1966</u> , <b>and that death occurred at</b> <u>M</u> , <b>from the causes and on the date stated above.</b>																				
<b>22a. SIGNATURE</b> <u>Richard H. Hunt</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MEO. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2366</u>												
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>RICHARD H. HUNT</u>						<b>22d. ADDRESS</b> <u>100 Cherry Lane, Glen Burnie, Md</u>														
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u>			<b>23b. DATE THEREOF</b> <u>2-1-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Calvary</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Beth Md 21225</u>												
<b>24. FUNERAL DIRECTOR</b> <u>Man Sam Roberts</u>						<b>ADDRESS</b> <u>638 N Gilmor St</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 3 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>										





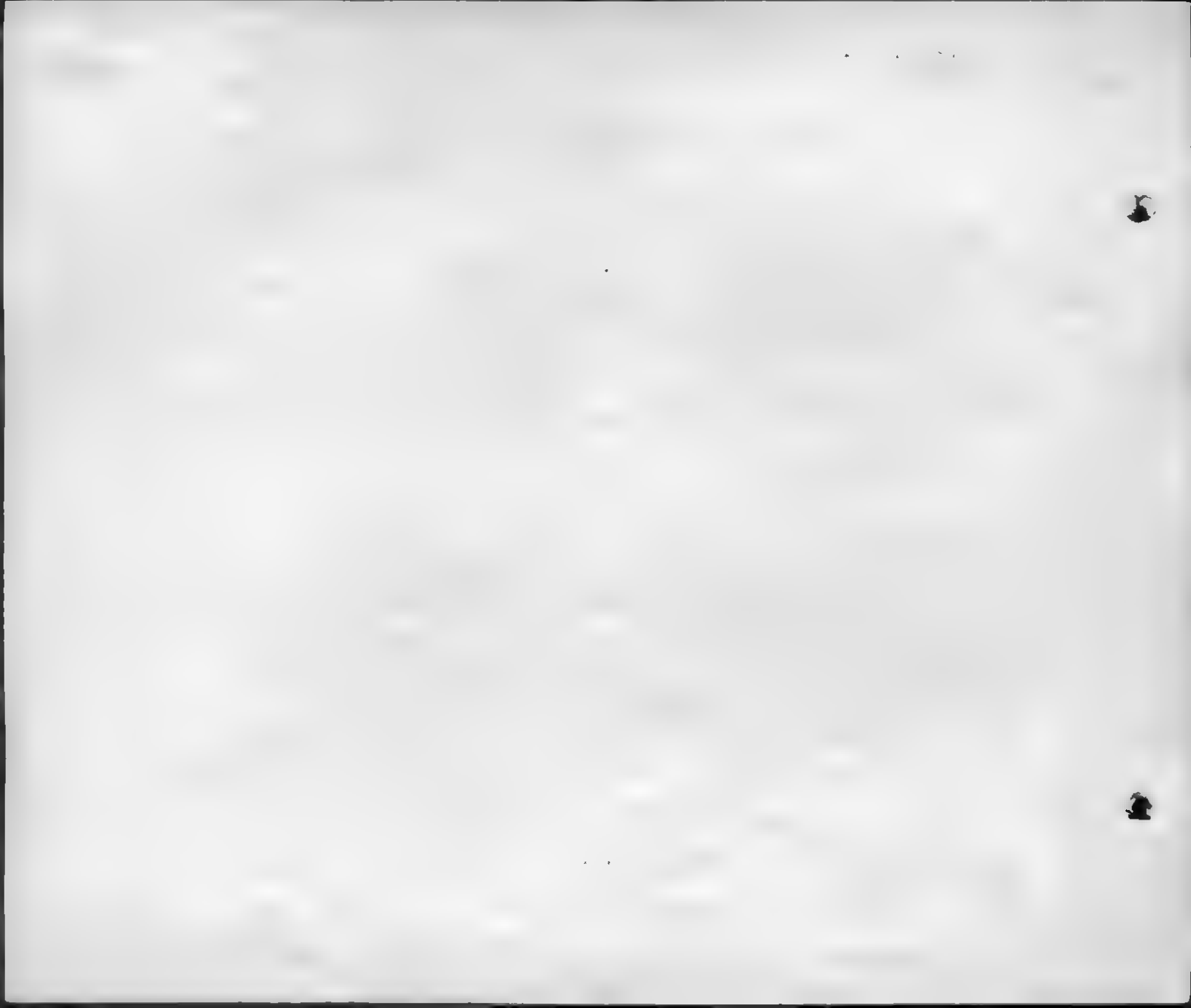
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
00156									
00149									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					d. STREET ADDRESS <u>28 Shaw St.</u>				
3. NAME OF DECEASED (Type or print) <u>CHESTINE</u> First <u>B.</u> Middle <u>MC CALL</u> Last					4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>19 66</u>				
5. SEX <u>female</u>					6. COLOR OR RACE <u>negro</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>2-24-1915</u>				
9. AGE (in years last birthday) <u>50</u> yrs.					10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>William McCall</u>					14. MOTHER'S MAIDEN NAME <u>Violetta Moore</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					17. INFORMANT <u>Eva Raddick</u> Address <u>110 Chester ave</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Rudiger Breiteneker</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>Rudiger Breiteneker, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED <u>1-5-66</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)									
22b. DATE THEREOF <u>1-8-1966</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>									
22d. LOCATION (City, town, or country) (State) <u>Annapolis Md.</u>									
23. FUNERAL DIRECTOR <u>William Reesett</u> ADDRESS <u>Annapolis Md.</u>									
24a. REC'D BY REGISTRAR <u>Charles Judge</u>									
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									
DATE <u>JAN 6 1966</u>									



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

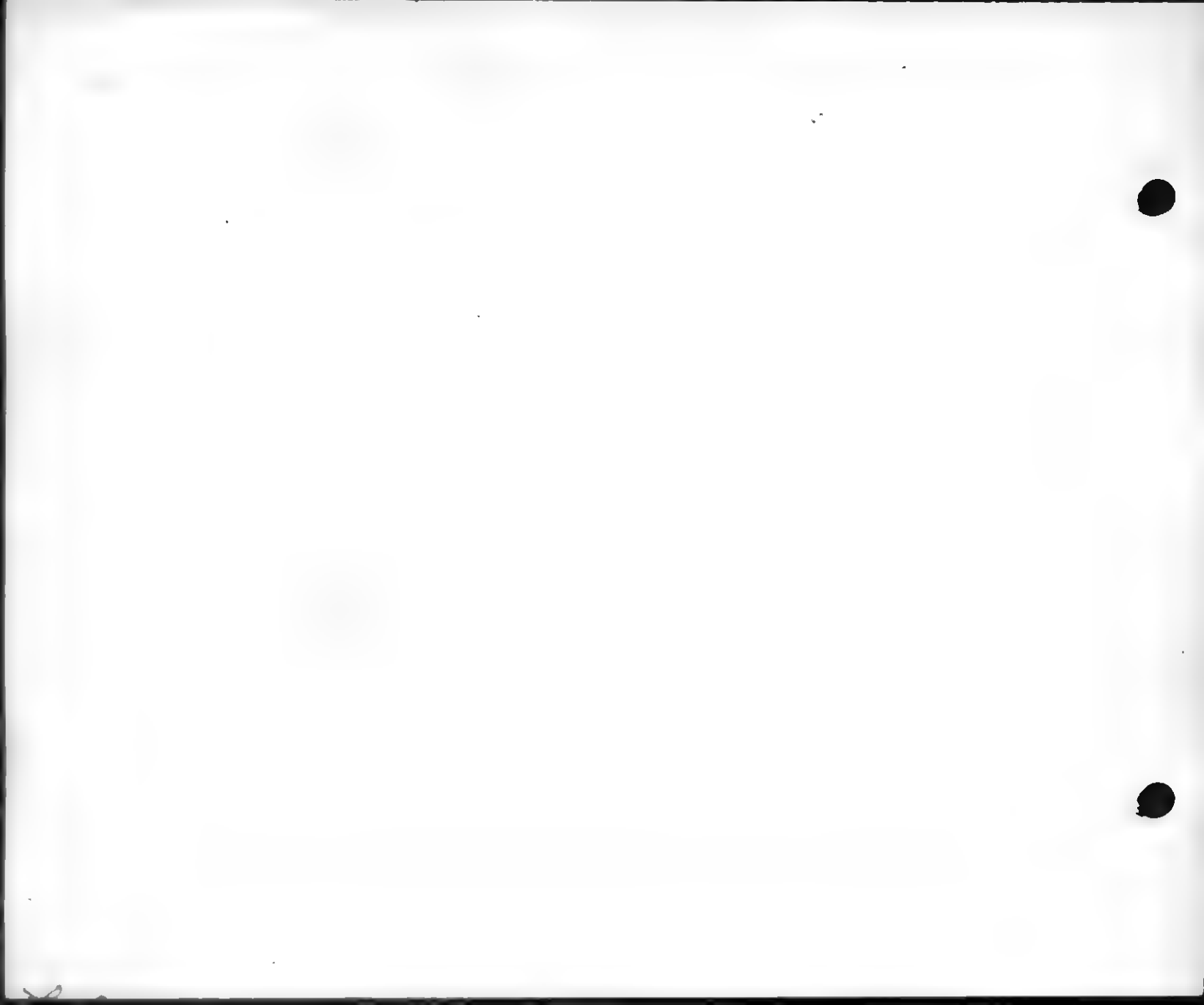
TO FUNERAL DIRECTOR: Page 3 should be filed as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>A. A. Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>H.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c LENGTH OF STAY IN 1b <u>Linthicum</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>O.O.A. - North - Arundel Hosp.</u>		d STREET ADDRESS <u>608 FAIRMONT AVE</u>	
3 NAME OF DECEASED (Type or print) <u>John A. McMahon</u>		4 DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/02/13</u>
10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>WELDER</u>		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>52</u> yrs
11 BIRTHPLACE (State or foreign country) <u>LA.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Joseph L McMahon</u>		14 MOTHER'S MAIDEN NAME <u>Eunice Mc Gee</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>F. Simily</u>		Address	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <u>1.26.66</u>			
23a BURIAL, CREMATION, REMOVAL, (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>1/30/66</u>	<u>Floral Gardens Park</u>	<u>High Point</u>
24 FUNERAL DIRECTOR <u>McCully F.H. 237 Patapsco ave</u>		25a REC'D BY REGISTRAR DATE <u>FEB 1 1966</u>	
ADDRESS <u>City 25, Md.</u>		25b REGISTRAR'S SIGNATURE <u>N.C.</u>	



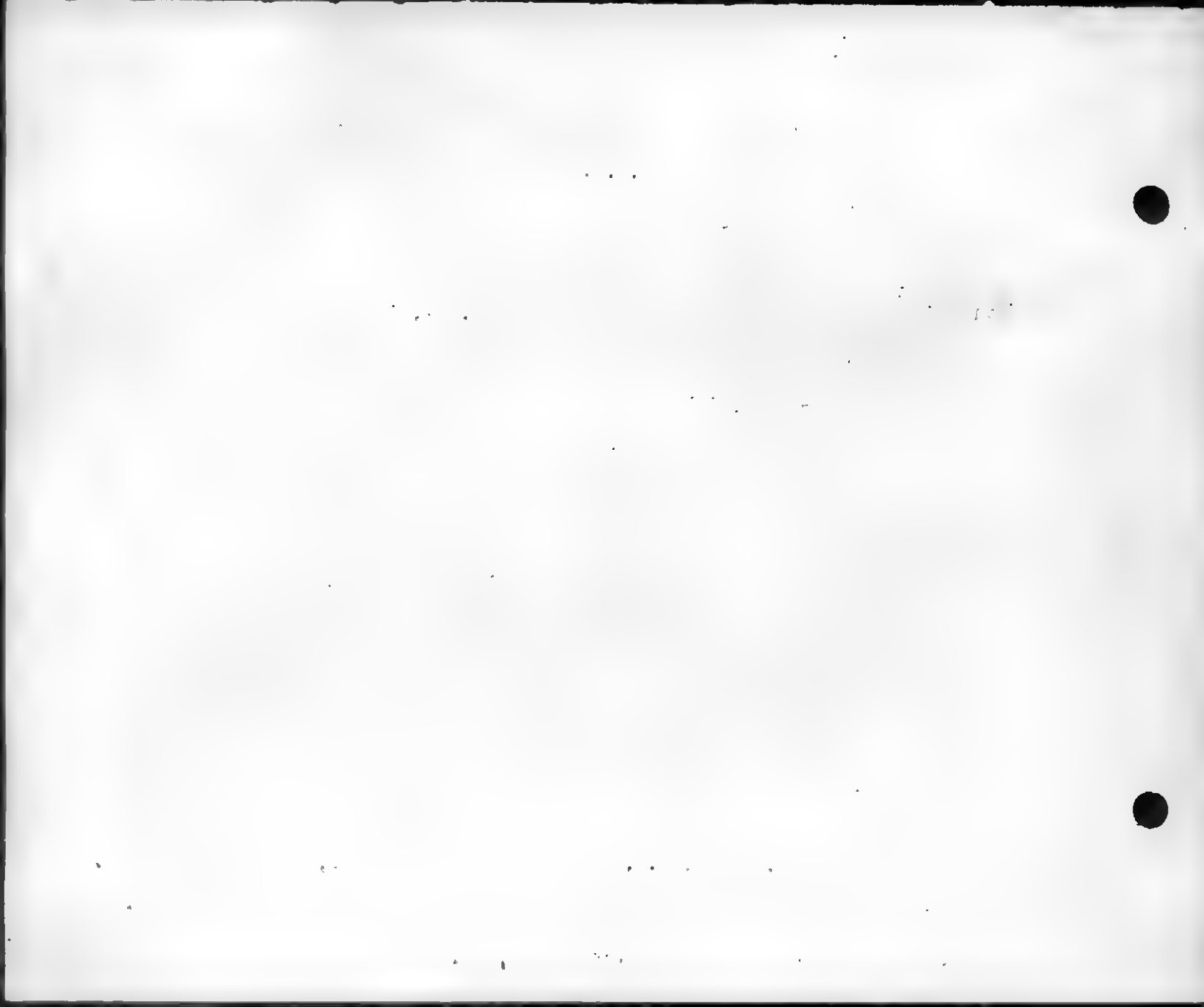
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00158 CERTIFICATE OF DEATH 00151											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>						d. STREET ADDRESS <b>107 Stauffer Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANCES</b>			First Middle Last <b>MILEWSKI</b>			4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 11, 1892</b>		9. AGE (in years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>-- Jozwiak</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>169 10 0354</b>		17. INFORMANT <b>Theresa Lindberg</b>			Address <b>Above</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Diabetes Mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>observed</del> attended the deceased from <b>1/4/</b> , 19 <b>66</b> , to <b>1/5/</b> , 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>1/4/</b> , 19 <b>66</b> , and that death occurred at <b>12:01 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Ray M. Smith</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/5/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Ray M. Smith, M.D.</b>						22d. ADDRESS <b>HahnProf Bldg., Severna Park, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Braddock Catholic Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Braddock, Pittsburg Pa.</b>			
24. FUNERAL DIRECTOR <b>Severna Park, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judo</b>			

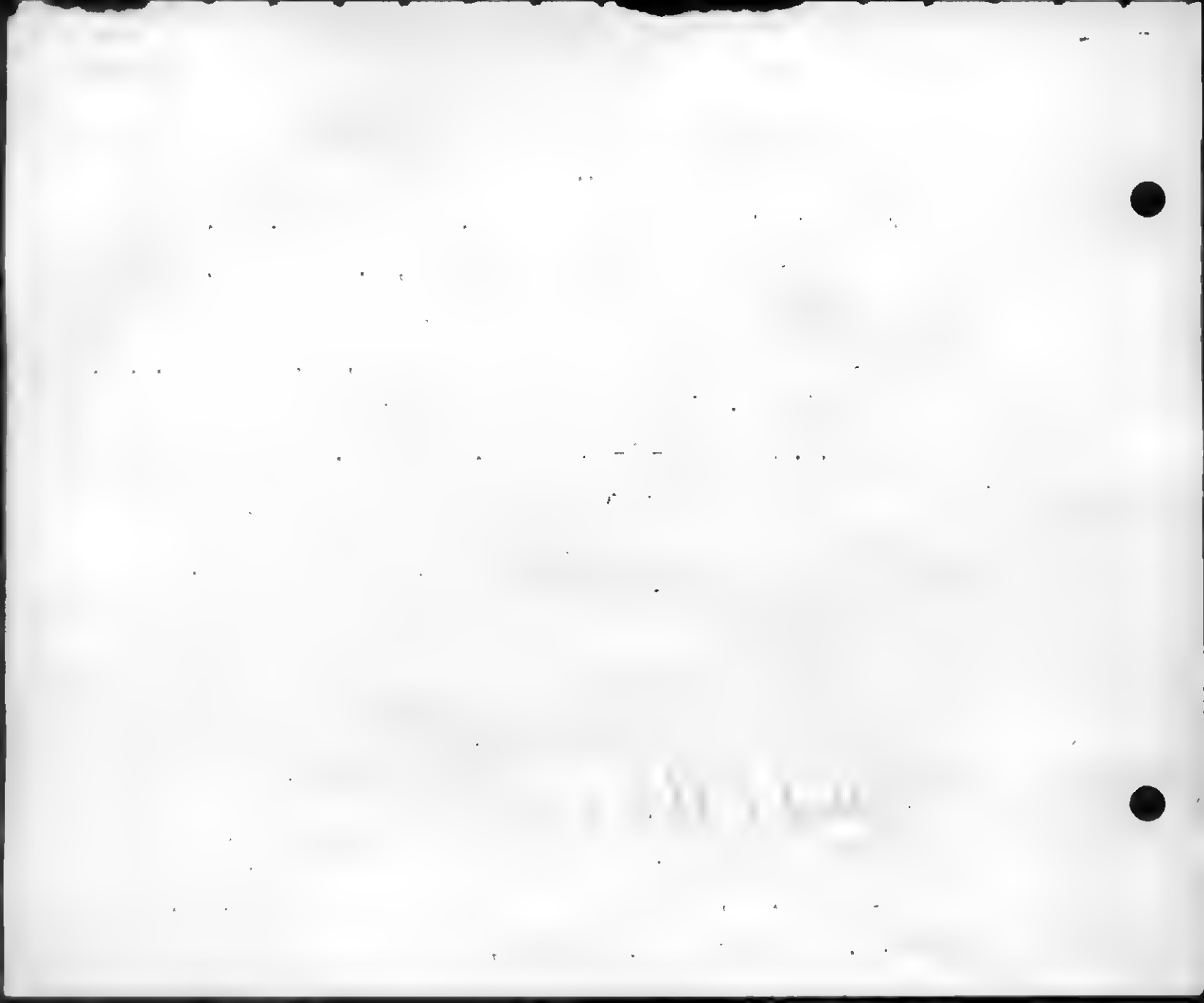
MEDICAL CERTIFICATION



TO COMPILE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>						c. LENGTH OF STAY IN 1b <u>1 Hr.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>						d. STREET ADDRESS <u>Rt. #1 Box 322 Maple Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>JESSE DUVALL MITCHELL, Sr.</u>						4. DATE OF DEATH <u>Jan. 25 19 66</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 26, 1898</u>		9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u>				11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William H. Mitchell</u>						14. MOTHER'S MAIDEN NAME <u>Lethia Glenn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>W.W. I 218-07-9784A</u>		17. INFORMANT <u>Mrs. Mildred M. Mitchell (wife) Same #2</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. <u>Coronary Occclusion.</u> DUE TO (b) 2. <u>Pulmonary Emphysema with chronic bronchi-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 3. <u>Arteriosclerotic heart disease with hyper-</u> 4. <u>Peptic ulcer.</u> tension. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u>No accident or injury.</u>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19 66</u> Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-17-</u> <u>1959</u> , to <u>1-8</u> <u>19 66</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> <u>19 66</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Albert F. Cooper M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Albert F. Cooper, M.D.</u>						22d. ADDRESS <u>206 Crain Highway, S.W. Glen Burnie, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>						ADDRESS <u>Glen Burnie, Md</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
						DATE <u>FEB 1 1966</u>					





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00160

00153

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A. A. Co</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>AA GENERAL HOSPT.</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u> d. STREET ADDRESS <u>RT 3 Box 25</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>WARFIELD H. MORELAND</u> First Middle Last			<b>4. DATE OF DEATH</b> Month Day Year <u>1 4 1966</u>		
<b>5. SEX</b> <u>M</u>			<b>6. COLOR OR RACE</b> <u>W</u>		
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>8-21-1904</u>		
<b>9. AGE</b> (In years last birthday) <u>61</u> yrs			<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>EMP-STATE ROADS COM. STATE OF MD</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>PRINCE GEORGE CO MD</u>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>PHILIP MORELAND</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>ALETHA GIBSON</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>LOLA M. MORELAND #2</u>		
<b>17. INFORMANT</b> Address <u>LOLA M. MORELAND #2</u>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chloroform anesthesia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> DUE TO (c) <u>1 1/2 hr</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II, of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year: Hour a.m. p.m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from ..... 19..... to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... M, from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>E. Linhart</u> M.D. <b>22b. DATE SIGNED</b> <u>1-4-66</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Charles Judge</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>1-7-66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ASBURY CEM.</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>ARNOLD AACo MD</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN M. TAYLOR, SONS</u> ADDRESS <u>ANNAPOLIS MD.</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 6 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

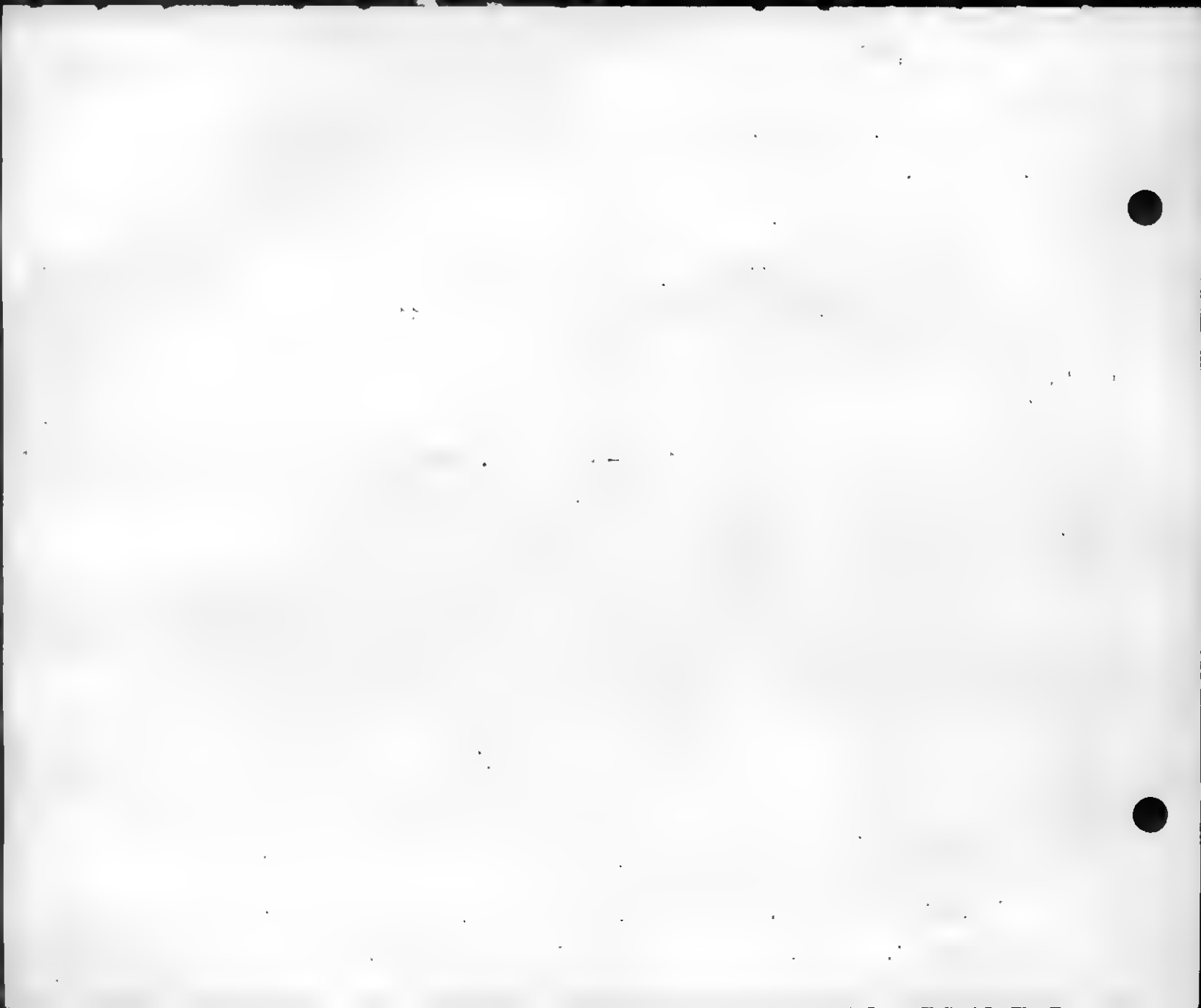
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

00161

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00154

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>GEORGIA</b> b. COUNTY <b>OXFORD</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b>				c. LENGTH OF STAY IN 1b <b>27 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>NORTH ARUNDEL GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>ROUTE # 1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILSON CARY NIMMO</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 18 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 31, 1901</b>	
9. AGE (in years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>METAL COMPANY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>TENNESSEE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>WILSON NIMMO</b>				14. MOTHER'S MAIDEN NAME <b>MARY RICKMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>411-16-2439</b>		17. INFORMANT <b>MRS. NANCY WELK</b> Address <b>RT 4 OLD COLUMBIA RD CITY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/29, 1965</b> to <b>1-18, 1966</b> , that (I) (we) last saw the deceased alive on <b>1-18, 1966</b> and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Ernest A. Leipold</b>				22b. DATE SIGNED <b>1/18/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Ernest A. Leipold</b>	
22d. ADDRESS <b>425 Ritchie Hwy S E Glen Burnie</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 21, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pfeiffer's Corner, Maryland</b>	
24. FUNERAL DIRECTOR <b>Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.</b>				25a. REC'D BY REGISTRAR <b>AN 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. W. Jones</b>	



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VR A15 (4)  
20M 1/65

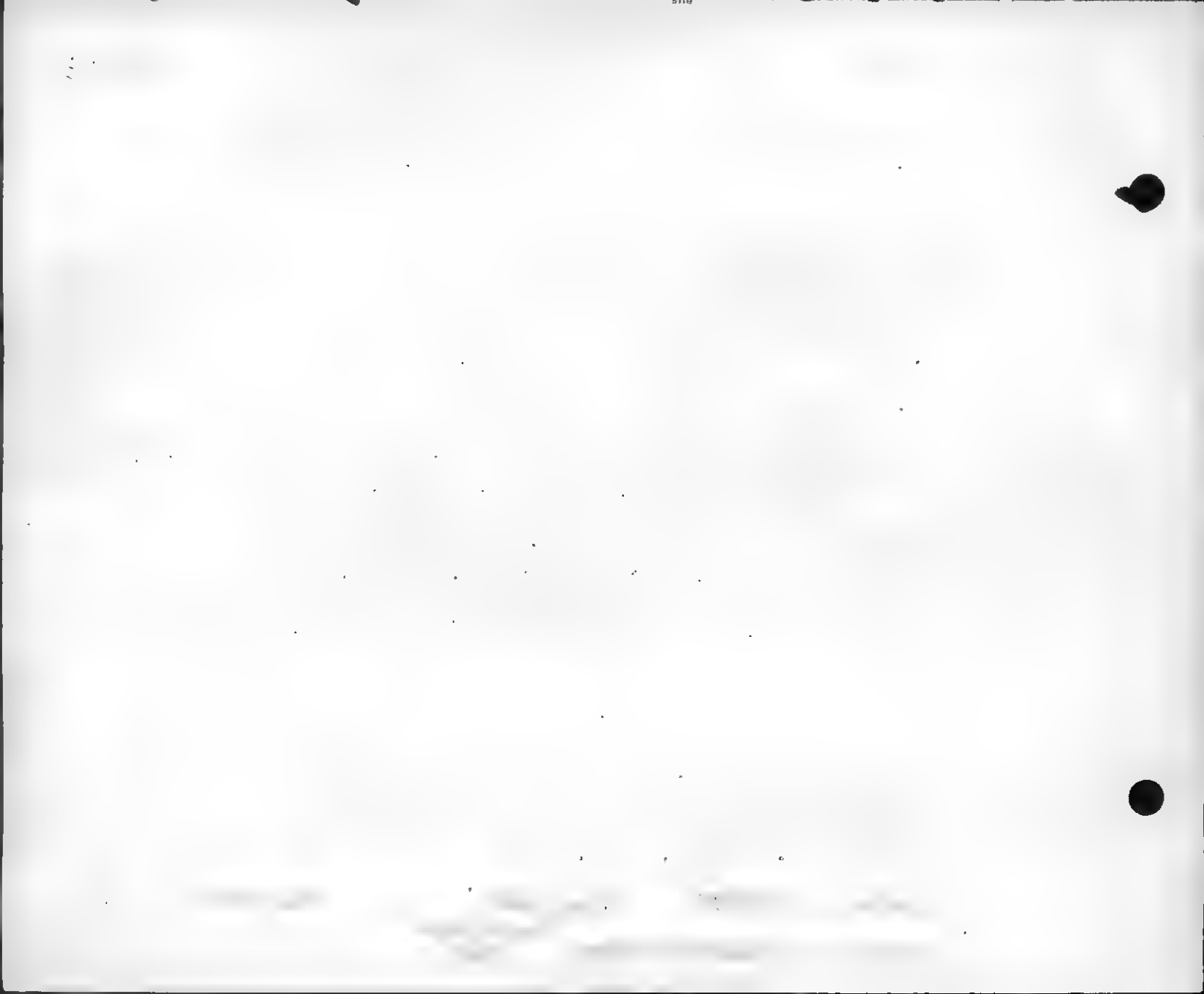
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00162

00155

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN ID <b>1 day</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural, Deale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>						e. STREET ADDRESS <b>Route 1</b>			f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Rosie Eleanor NUTWELL</b>		First <b>Rosie</b>		Middle <b>Eleanor</b>		Last <b>NUTWELL</b>		4. DATE OF DEATH <b>January 1 1966</b>		Month <b>January</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr 23, 1881</b>		9. AGE (in years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Calvert Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>George GIBBS</b>						14. MOTHER'S MAIDEN NAME <b>Rosie WELLS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Marion Nutwell Marshall (daughter)</b> <b>Route 1, Box 457, Deale, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior myocardial infarction</b> DUE TO (c) <b>Arteriosclerotic cardiovascular dis.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>10 hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aortic stenosis, Ventricular arrhythmia, Cheyne-Stokes respiration</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>Jan. 1, 1966</b> to <b>Jan 1, 1966</b> , that (I) <del>was</del> last saw the deceased alive on <b>Jan 1, 1966</b> , and that death occurred at <b>7:35 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Charles W. Kinzer</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 1, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>						22d. ADDRESS <b>So. River Med. Cent. Edgewater, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-4-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>QUAKER</b>				23d. LOCATION (City, town or county) (State) <b>GALESVILLE, MD.</b>			
24. FUNERAL DIRECTOR <b>HARDESTY FUNERAL HOME</b>				ADDRESS <b>GALESVILLE MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. W. Jones</b>			

MEDICAL CERTIFICATION

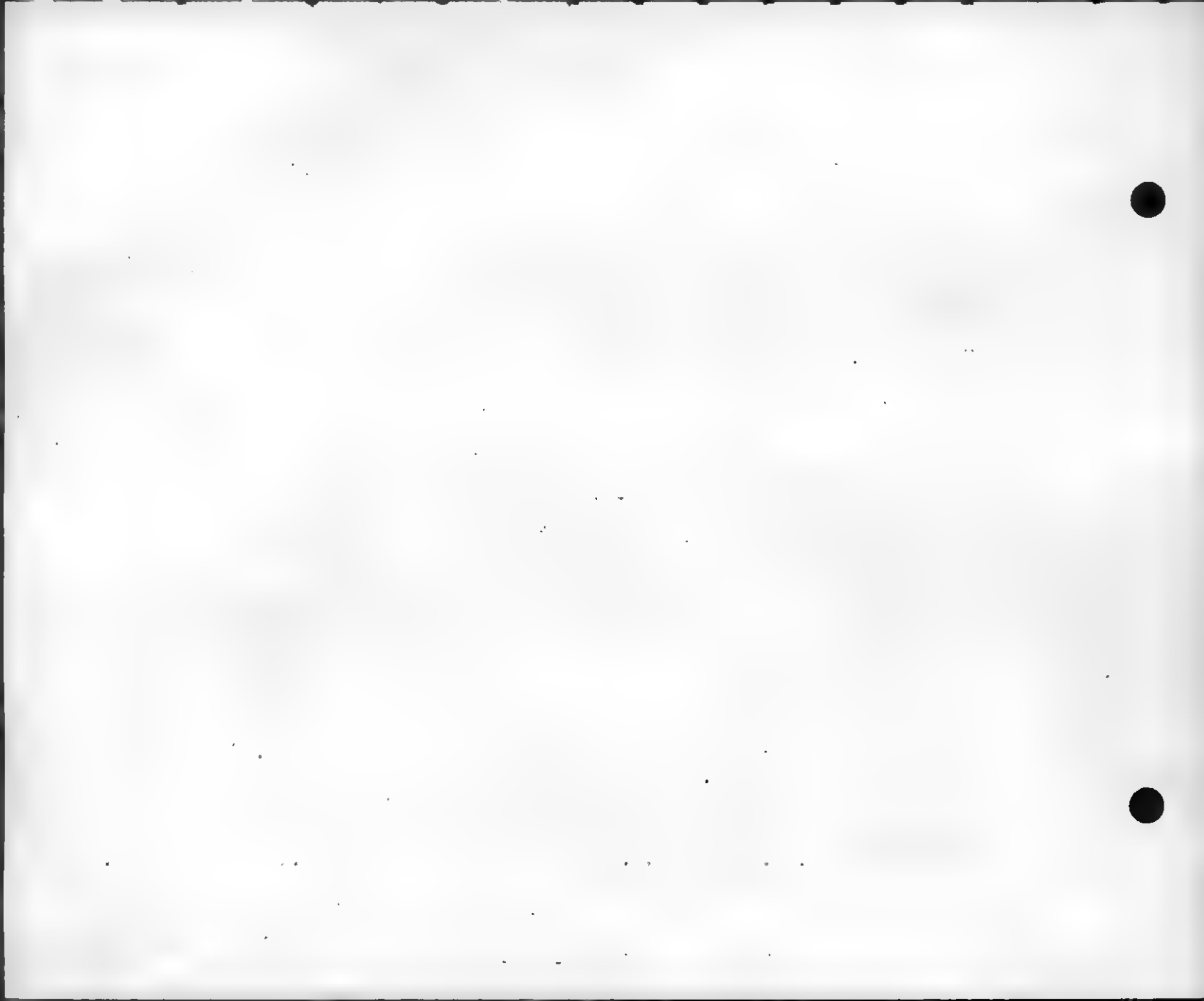


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00163  
CERTIFICATE OF DEATH  
00156

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Francis OGLE		4. DATE OF DEATH Month Day Year January 21 1966			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-2-1884		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Hawkins		14. MOTHER'S MAIDEN NAME Florence W. Wynn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 25-16-567		17. INFORMANT Daisy Balls 1249 S. Caroline St. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (b) Scurvy, General Debility (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from 1-15-66, 19, to Jan. 21, 1966, that (I) (the) last saw the deceased alive on Jan. 21, 1966, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE A. T. Allen	
22b. DATE SIGNED 11:00 AM		22c. PHYSICIAN'S NAME (Type) A. T. Allen, M.D.		22d. ADDRESS 62 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-1966		23c. NAME OF CEMETERY OR CREMATORY Waterbury	
23d. LOCATION (City, town or county) (State) Md.		24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR JAN 24 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					





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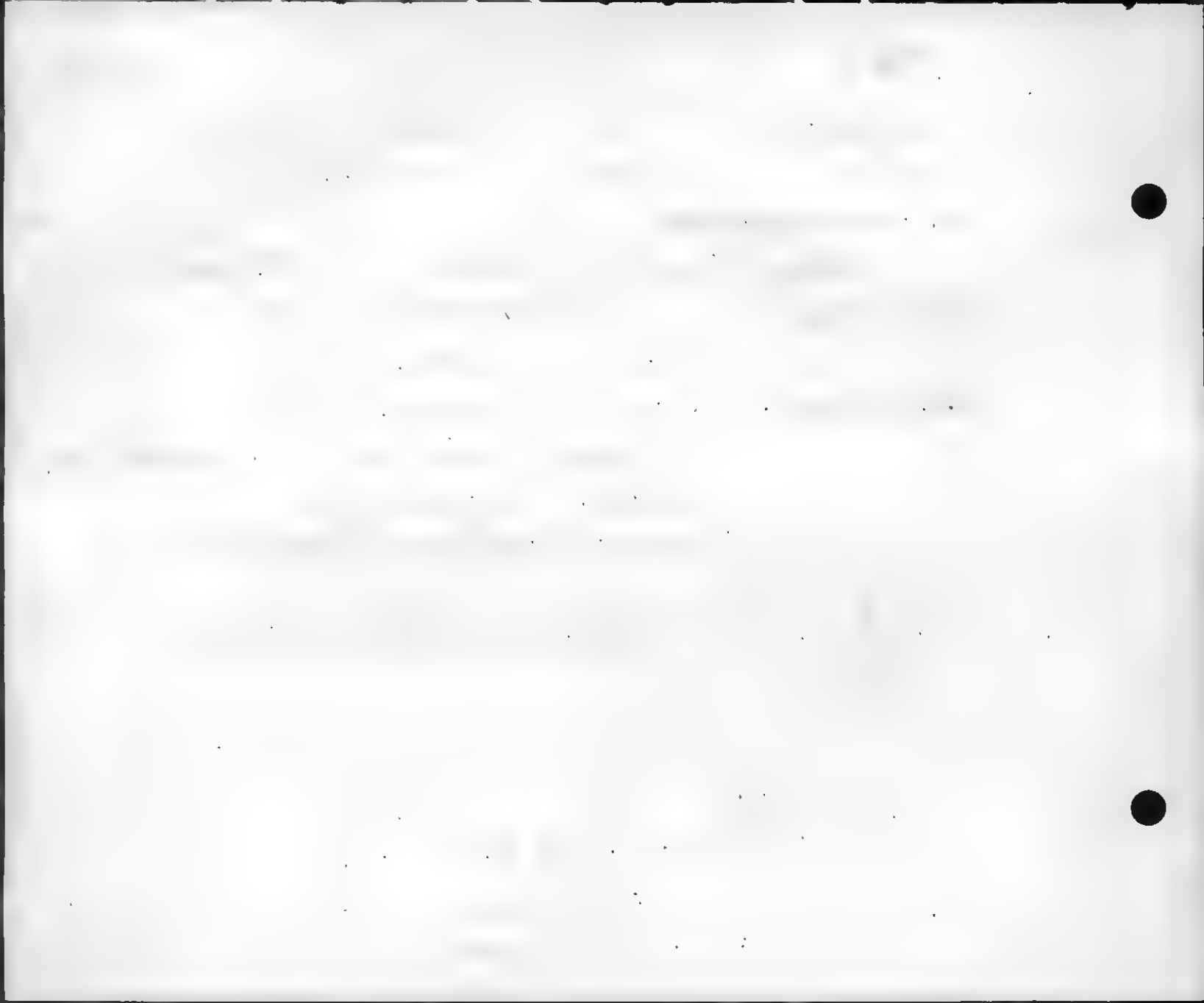
VR A15 (4)  
20M 1/65

00164

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00157

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u> c. LENGTH OF STAY IN ID <u>2 WKS.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville St. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>St. Marys</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonard town</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Freeman</u> First Middle Last 4. DATE OF DEATH <u>JANUARY 23 1966</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-12-1882</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Alexander Owens</u> 14. MOTHER'S MAIDEN NAME <u>Susan ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-36-2616</u> 17. INFORMANT <u>Hospital chart - Crownsville, Md.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Chronic Brain Syndrome due to the above; Dehydration Anemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to the above; Dehydration Anemia</u> INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 7</u> , 19 <u>66</u> , to <u>Jan 23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 26</u> , 19 <u>66</u> , and that death occurred at <u>6:25 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Donald McHenry Mapp MD</u> 22b. DATE SIGNED <u>Jan 23 1966</u> 22c. PHYSICIAN'S NAME (TYPE) <u>Donald McHenry Mapp MD</u> 22d. ADDRESS <u>Crownsville State Hospital, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-25-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St Aloysius</u> 23d. LOCATION (City, town or county) (State) <u>Leonard town, Md</u>	
24. FUNERAL DIRECTOR <u>George Wallingford Leonardtown, Md</u> ADDRESS 25a. REC'D BY REGISTRAR <u>JAN 26 1966</u> 25b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

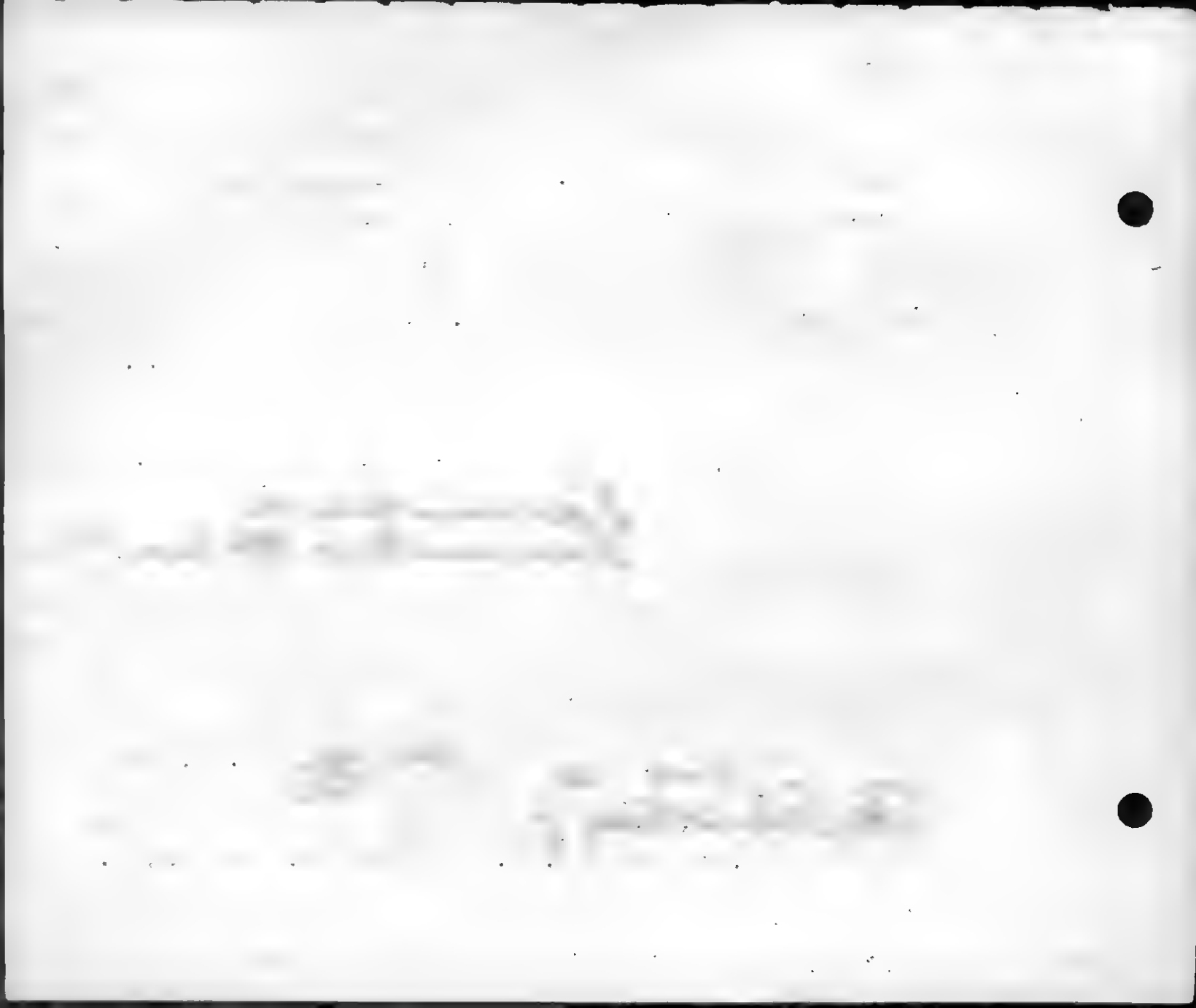
00165

00158

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN ID <b>35 Min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Rt-2, Box-398</b>			
3. NAME OF DECEASED (Type or print) <b>Baby</b>				4. DATE OF DEATH <b>January 25 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 25, 1966</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Anne A. undel Maryland,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Rosie Lee Pack</b>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>17. INFORMANT <b>Rosie Lee Pack, Rt. 2, Severna Park, Md.</b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO (b) <b>Immature of the liver</b> DUE TO (c) <b>35/c</b>							INTERVAL BETWEEN ONSET AND DEATH <b>35/c</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>not hospital</b> attended the deceased from <b>1/25, 1966</b> to <b>Jan. 25, 1966</b> , that (I) <b>not</b> last saw the deceased alive on <b>1/25 1966</b> and that death occurred at <b>11:30</b> from the causes and on the date stated above.							22b. DATE SIGNED <b>1/26/66</b>
22a. SIGNATURE <b>Stuart M. Christilf, Jr. MD.</b>				22c. ADDRESS <b>69 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-30-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salas</b>	
24. FUNERAL DIRECTOR <b>William R. Bissett, Annapolis, Md.</b>				25a. REC'D BY REGISTRAR <b>1/27/66</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. R. Bissett</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9 60

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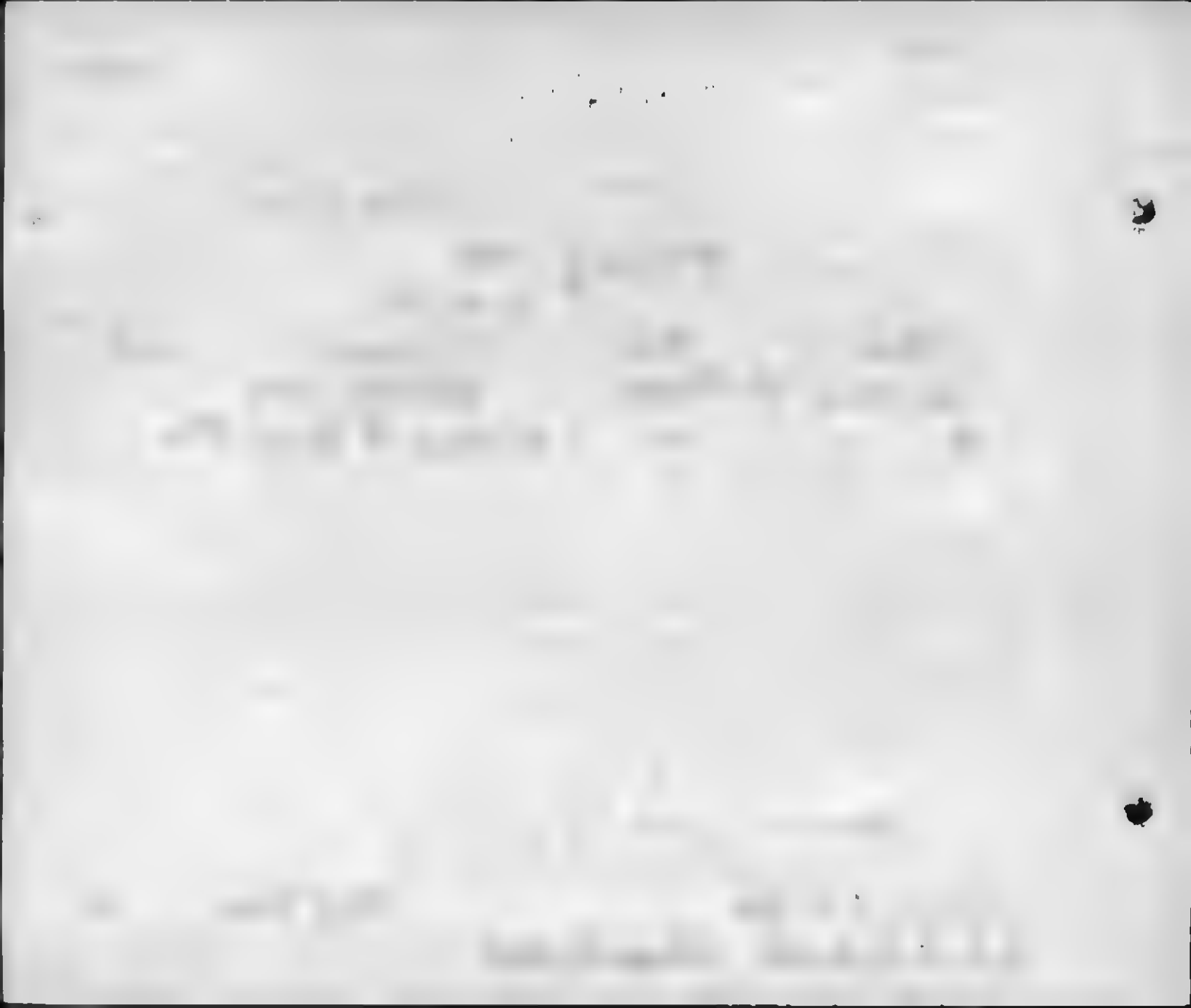
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00159

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>				d. STREET ADDRESS <u>7 Melrob Court</u>			
3. NAME OF DECEASED (Type or print) First <u>Keith</u> Middle <u>McDonald</u> Last <u>PERRY</u>				4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-1965</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years last birthday) yrs. <u>3</u>		11. BIRTHPLACE (State or foreign country) <u>Front Royal, Virginia</u>	
13. FATHER'S NAME <u>William M. Perry</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Via</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of serv. ca.) <u>No</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>William M. Perry</u> Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last, (c) <u>—</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral otitis media</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Werner U. Spitz</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22b. DATE THEREOF <u>5-31-1966</u>				DATE SIGNED <u>1/28/66</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis, Md.</u>				22d. LOCATION (City, town, or country) (State) <u>Front Royal Va.</u>			
23. FUNERAL DIRECTOR <u>John M. Saylor &amp; Sons</u>				24a. REC'D BY REGISTRAR <u>FEB 2 1966</u>			
ADDRESS <u>Annapolis, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> c. LENGTH OF STAY IN 1b <b>18 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Children's Center Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1126 Neal St., N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Charles Petty</b>			4. DATE OF DEATH <b>January 26 1966</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <b>6-6-40</b>			9. AGE (in years last birthday) <b>26</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Petty</b>			14. MOTHER'S MAIDEN NAME <b>Edith Callens</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Children's Center Hospital, Laurel, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> <b>3255</b> DUE TO (b) <b>Spastic quadriplegia - severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Mental retardation - severe</b>									INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 19 1948</b> , to <b>January 26 1966</b> , that (I) (we) last saw the deceased alive on <b>January 26, 1966</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>James E. Boyland</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-27-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>JAMES E. BOYLAND, M. D.</b>			22d. ADDRESS <b>Children's Center Hospital, Laurel, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <b>2-1-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Children's Center</b>		23d. LOCATION (City, town or county) (State) <b>Laurel Md</b>			
24. FUNERAL DIRECTOR <b>DeWitt Danielson, Laurel Md</b>			ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





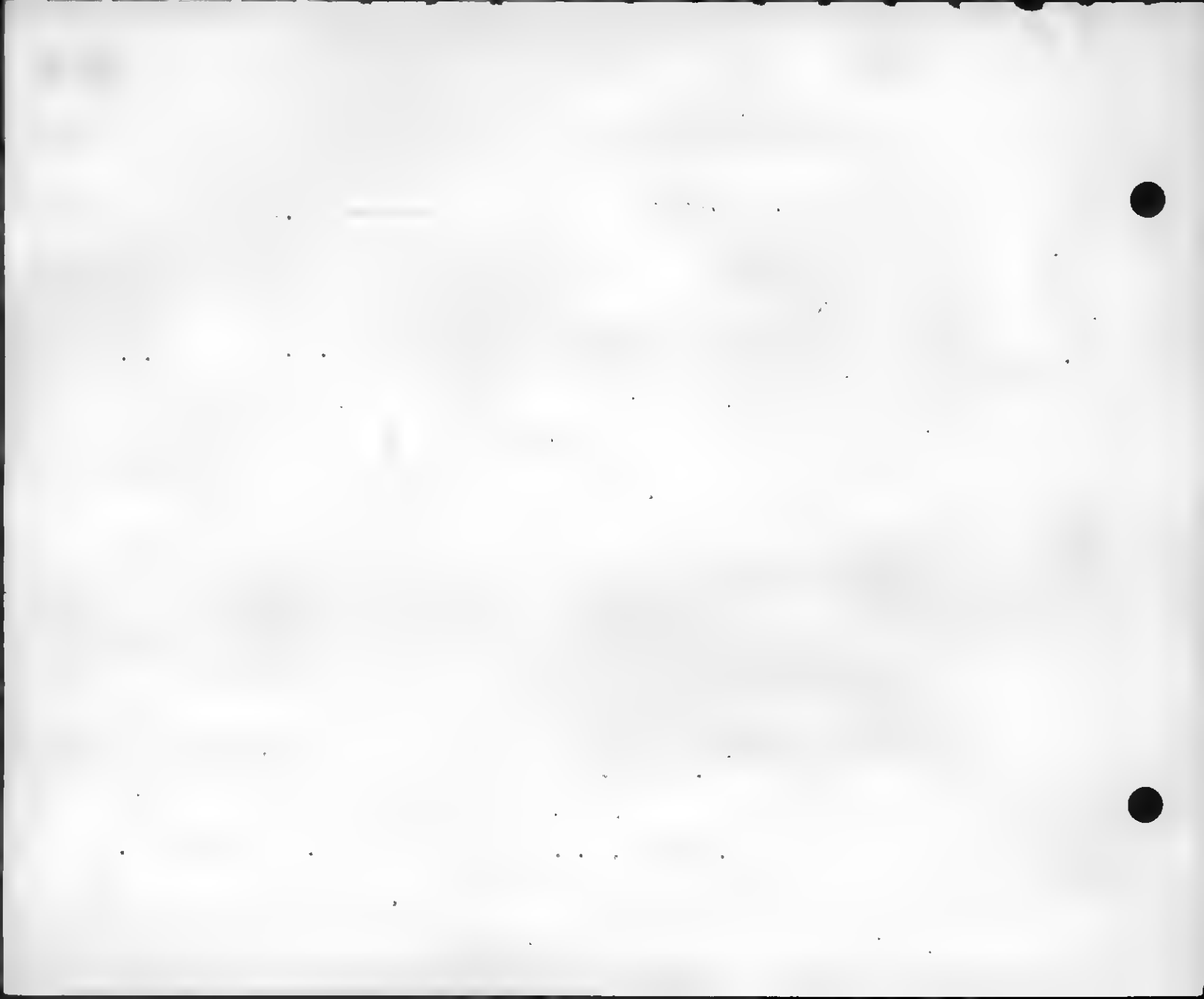
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00168 CERTIFICATE OF DEATH 00161

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>77 Northwest St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Eva</b> Last <b>PINKNEY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>19 66</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1905</b>		9. AGE (in years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic, private, Md. State</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Wade</b>				14. MOTHER'S MAIDEN NAME <b>Clara Howard</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212184135</b>		17. INFORMANT <b>George Pinkney</b> Address <b>77 N. West St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>extrenal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>4:10 AM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I am a physician who attended the deceased from <b>1/12</b> , 19 <b>66</b> , to <b>Jan. 12</b> , 19 <b>66</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Jan. 12</b> , 19 <b>66</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/13/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. Hochman, M.D.</b>				22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1-16-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brownsville</b>		23d. LOCATION (city, town or county) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR <b>William Beesett</b> ADDRESS <b>Annapolis</b>				25a. REC'D BY REGISTRAR <b>James Judge</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	
				DATE <b>JAN 17 1966</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

00169

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00162

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Virginia</b>				b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>1 hour</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>								d. STREET ADDRESS <b>5408 N. Washington Blvd.</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Reed</b> Last <b>Porter</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>22</b> Year <b>19 66</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1904</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>				11. BIRTHPLACE (County & State, or foreign country) <b>unknown</b>			
13. FATHER'S NAME <b>James R. Porter</b>				14. MOTHER'S MAIDEN NAME <b>Clara W.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-28-23-66</b>				17. INFORMANT <b>Mrs. C. E. Carrico - 3805 Theyer Ct. Fairfax Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct.</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO (c) <b>Hypertension. ?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Obesity.</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b></b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20 Dean Street, Annapolis</b>			
20f. (City or town) (County) (State) <b>Annapolis, Md.</b>											
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 22 1966</b> to <b>Jan 22 1966</b> ; that (I) (we) last saw the deceased alive on <b>Jan 22 1966</b> , and that death occurred at <b>4:37 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Lionel M. Henry Mapp, MD</b>								22b. DATE SIGNED <b>1/23/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lionel M. Henry Mapp, MD</b>								22d. ADDRESS <b>20 Dean Street, Annapolis</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>				23b. DATE THEREOF <b>1/23/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			
23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>Jan 26 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
24. FUNERAL DIRECTOR <b>Scrubby E. Hopping</b>				ADDRESS <b>Hopping Funeral Home Annapolis, Md.</b>							

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

00170

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00168

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1107 Houghton Rd.</u>				d. STREET ADDRESS <u>1107 Houghton Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>GUARDIAN E. PUGH</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1909</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>nowell, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Cecil Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Ester Zumwalt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Samuel S. Pugh - 1107 Houghton Rd.</u>				Address <u>---</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4500</u> DUE TO (b) <u>---</u> Conditions, if any, which gave rise to immediate cause (c) <u>---</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F. L. [Signature]</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 6, 1966</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>				22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Maryland</u>			
23. FUNERAL DIRECTOR <u>George J. Gonce</u>				24a. REC'D BY REGISTRAR <u>JAN 7 1966</u>			
ADDRESS <u>4001 Ritchie Hwy., Baltimore</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in the case of death in the home, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00171

00164

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FORT GEO. G. MEADE</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>COLORADO</b> b. COUNTY <b>EL PASO</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>XXXXXXXXXXXX SECURITY</b> d. STREET ADDRESS <b>505 ASPEN DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM EDWARD RICHARD</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 1 19 66</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>19 DEC 1907</b>		9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TOBACCO COMPANY</b>				11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN Charles A. Rosenthal</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN Mildred S. White</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES UNKNOWN</b>			
16. SOCIAL SECURITY NO. <b>090-03-5618</b>				17. INFORMANT <b>ROBERT E. RICKARD</b>				Address <b>ENT AFB COLORADO SPRINGS, COLORADO</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CIRCULATORY COLLAPSE</b> <b>5020</b> DUE TO (b) <b>PULMONARY INSUFFICIENCY, CHRONIC BRONCHITIS</b> DUE TO (c) <b>AND EMPHYSEMA WITH ACUTE EXSCERBATION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <b>1 JAN</b> , 19 <b>66</b> , to <b>1 JAN</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>27 DEC</b> , 19 <b>65</b> , and that death occurred at <b>4:56 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Benjamin E. Dunlap</b>								22b. DATE SIGNED <b>1 Jan 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN E. DUNLAP, CAPT, MC</b>								22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL, FT GEO G MEADE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/5/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City, town or county) (State) <b>Parkville, Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>								25a. REC'D BY REGISTRAR <b>JAN 3 1966</b>			
								25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





1. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00112

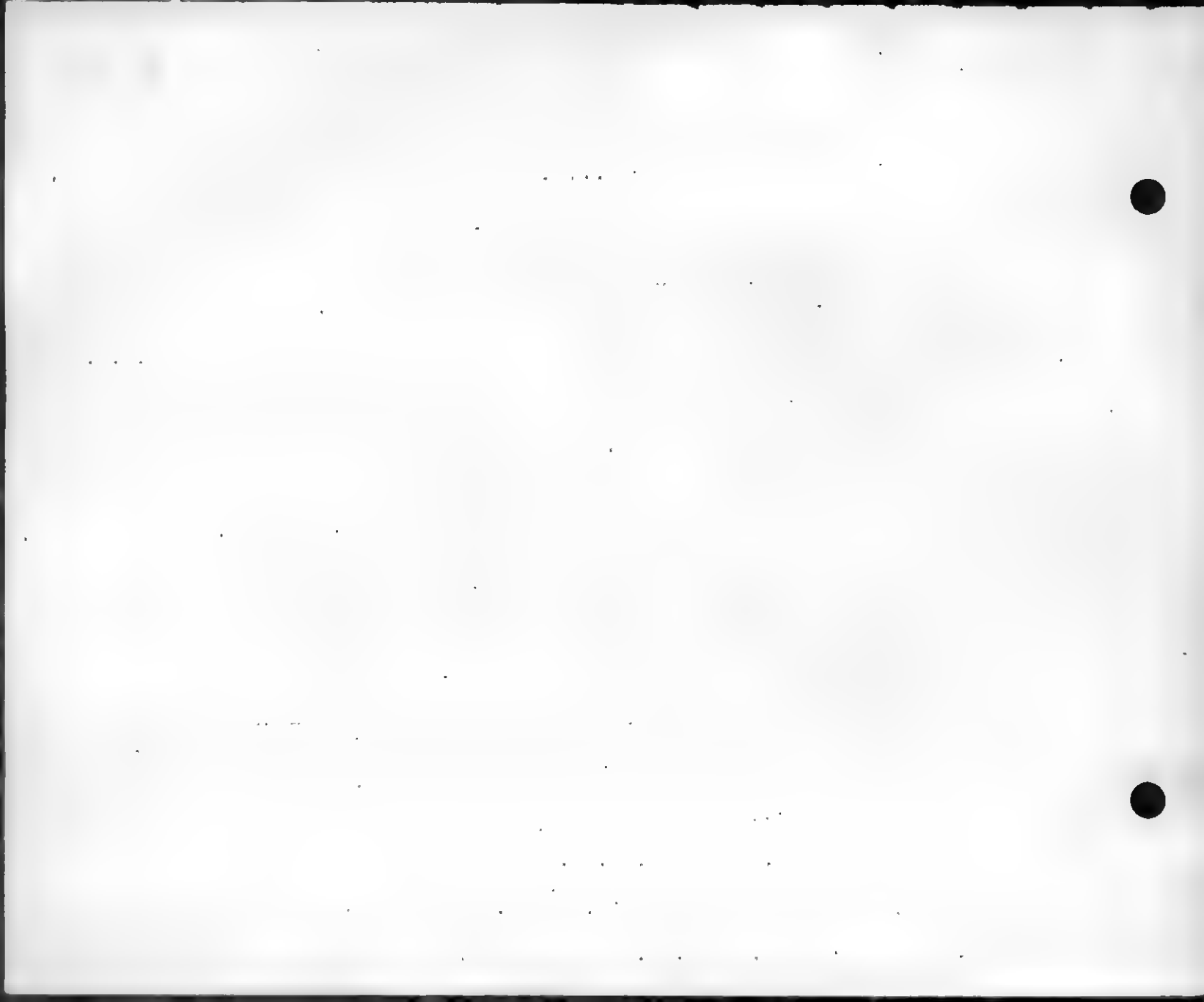
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00165

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>3 mos. 25 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> <u>02-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Box 201 St. 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>3-#30399 Thomas Robinson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 13, 1892</u> <u>73</u> yrs.	
9. AGE (in years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dan Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1918</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebrovascular Accident with Hemiplegia</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. --- 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>65</u> , to <u>1/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> , 19 <u>66</u> , and that death occurred at <u>10:21</u> A.M. from the causes and on the date stated above.							22b. DATE SIGNED <u>1/19/66</u>
22a. SIGNATURE <u>[Signature]</u>		22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		23d. LOCATION (City, town or county) (State) <u>Arnold, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Reese II</u>		24a. REC'D BY REGISTRAR <u>108 W. Wash. St., Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		24c. DATE <u>JAN 20 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

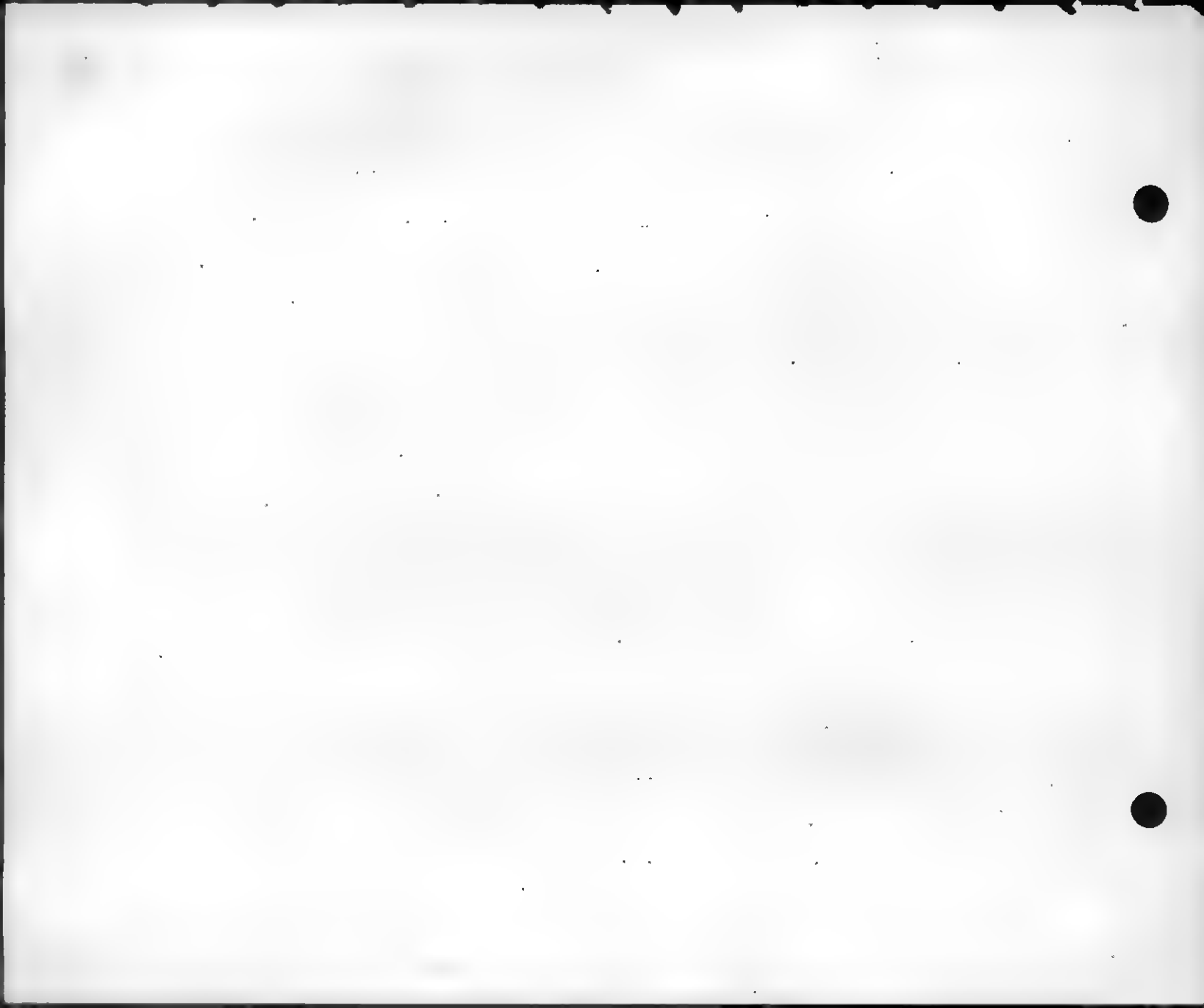
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00173

00166

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel County</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <span style="float: right;">30-4</span> d. STREET ADDRESS <u>313 N. Ellwood St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Albert T. Rochfort</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>6</u> Year <u>19 66</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/23/1888</u>		<b>9. AGE</b> (in years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self-employed</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Thomas Rochfort</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie O'Brian</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>				<b>17. INFORMANT</b> <u>Hospital Records</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, Acute</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Chronic Brain Syndrome Sec. General Arteriosclerosis</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) -----									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. ----- p.m. ----- <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>9/11/</u>, 19<u>64</u>, to <u>1/6/</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>1/6/</u>, 19<u>66</u>, and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>[Signature]</u>						<b>22b. DATE SIGNED</b> <u>1/5/66</u>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>L. Benedict, M.D.</u>						<b>22d. ADDRESS</b> <u>Crownsville State Hospital</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>1/7/66</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>John E. Moran, Inc.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>						<b>25c. DATE</b> <u>JAN 10 1966</u>									



# MARYLAND STATE DEPARTMENT OF HEALTH

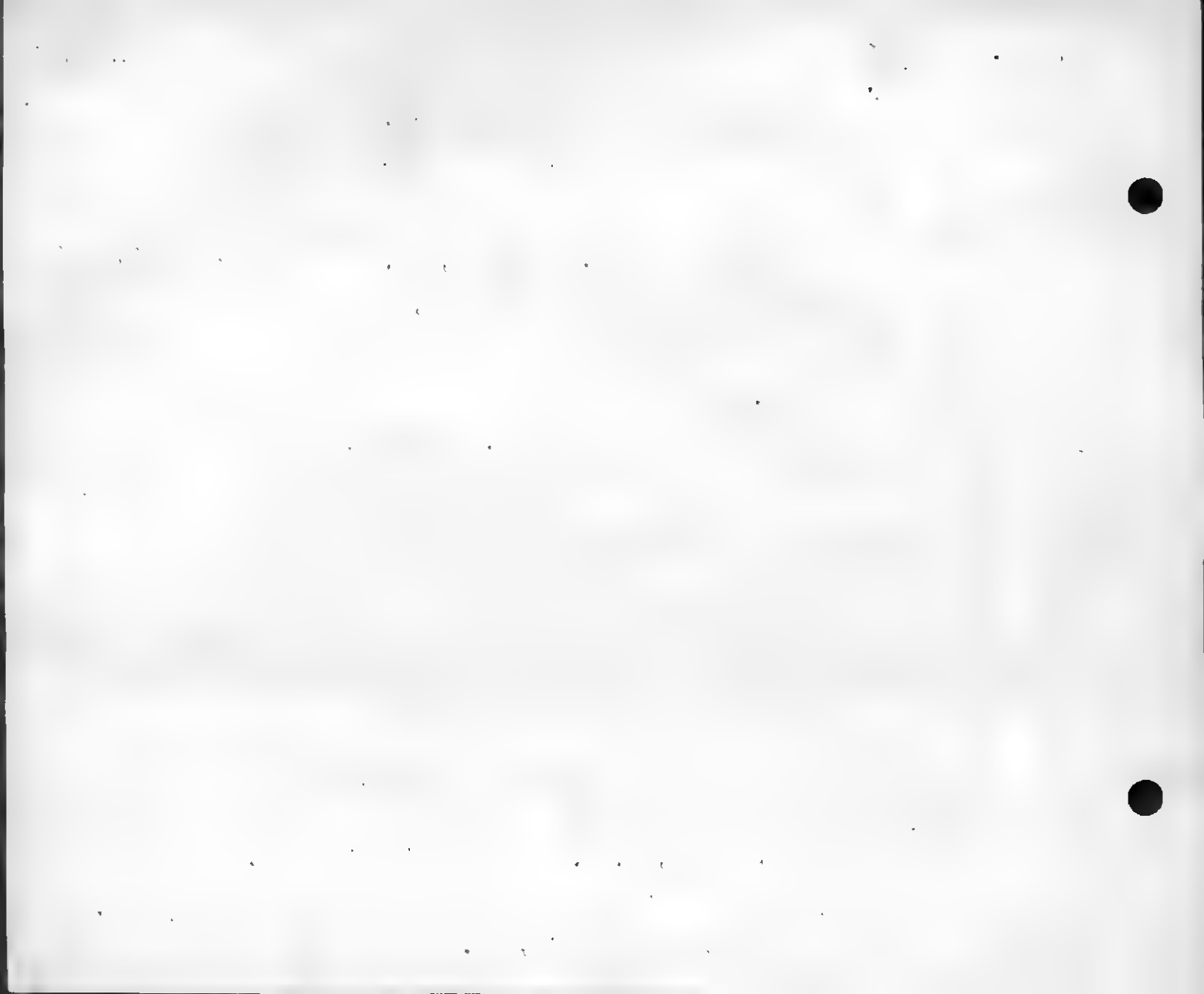
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00174

00167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN ID <b>7 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>513 Manor Road</b>				d. STREET ADDRESS <b>513 Manor Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harold J. Rogers, Sr.</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>3,</b> Year <b>1966</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1908</b>	9. AGE (In years last birthday) <b>57 yrs.</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>3</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USCG Yard</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert A. Rogers</b>				14. MOTHER'S MAIDEN NAME <b>Mabel Duncan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>Mrs. Aileen B. Rogers, same as 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO <b>Carcinomatous Generalized</b> DUE TO <b>Carcinoma of Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>N/A</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>65</b> , to <b>Jan 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 3, 1966</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Max C. Frank, M. D.</b>				22b. DATE SIGNED <b>1/3/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Max C. Frank, M. D.</b>	
22d. ADDRESS <b>425 Ritchie Hwy., Glen Burnie</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/6/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME  
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00175

00168

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A. Co</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RT 1 Box 130</u>		d. STREET ADDRESS <u>RT 1 Box 130</u>	
3. NAME OF DECEASED (Type or print) <u>LOUIS</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>14</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-13 14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIP BUILDING</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>DEANNA ZIEGLER</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Chronic sinusitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic sinusitis</u> DUE TO <u>Tumor</u> (c) <u>Chronic sinusitis</u> DUE TO <u>Tumor</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-14-66</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-17-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>		22d. LOCATION (City, town, or county) (State) <u>St. Anne's, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert A. Bernance, Seaside Park, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 18 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>John C. Judge</u>		DATE SIGNED <u>1-14-66</u>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and by any event, within 72 hours after death.

00176

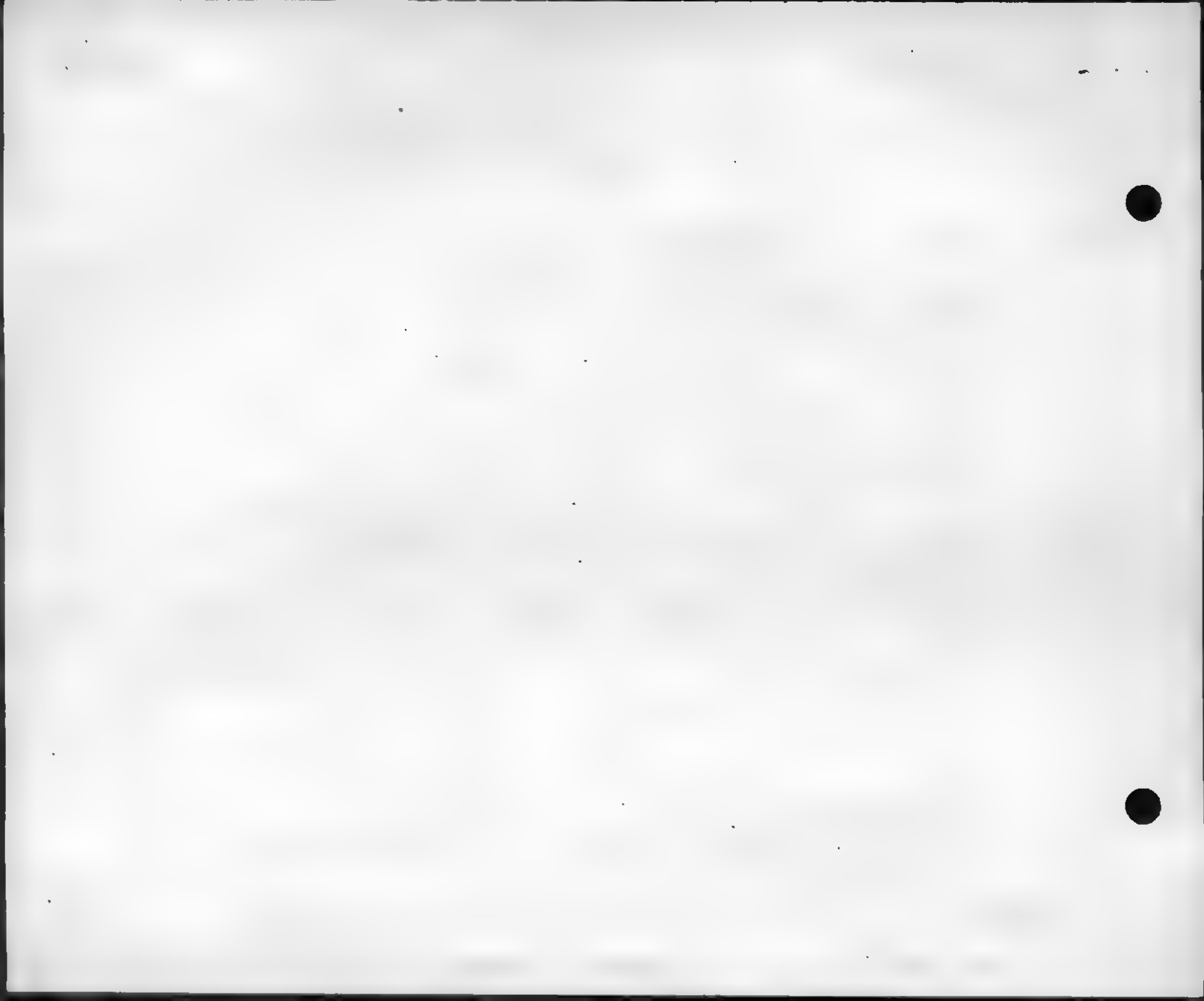
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00169

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>		c. LENGTH OF STAY IN 1b <i>5 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>none</i>				d. STREET ADDRESS <i>Edgewood Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Melvin Frederick Sapp</i>				4. DATE OF DEATH Month <i>January</i> Day <i>5</i> Year <i>1966</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 14, 1904</i>	9. AGE (In years last birthday) <i>61</i> yrs.	10. FUNERAL 1 YEAR	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>machin</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A.S. Well Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Frederick Sapp</i>				14. MOTHER'S MAIDEN NAME <i>Mary E. Stroth</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-13-3188</i>		17. INFORMANT Address <i>Mrs Melvin Sapp Laone</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the left lung</i> DUE TO (b) <i>pulmonary emphysema</i> DUE TO (c) <i>none</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>1 year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <i>December 1, 1964</i> to <i>January 5, 1966</i> ; that (I) (we) last saw the deceased alive on <i>January 2, 1966</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>R.M. McLaughlin</i>				22b. DATE SIGNED <i>1/5/66</i>		22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8 Jan 1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i>		23d. LOCATION (City, town or county) (State) <i>Howard Co Md</i>		
24. FUNERAL DIRECTOR <i>Singloton Funeral Home/Robertson</i>		25a. REC'D BY REGISTRAR <i>JAN 10 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place of removal of carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

788

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Anne Arundel</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i> c. LENGTH OF STAY IN 1b <i>16 yrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>none</i>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i> d. STREET ADDRESS <i>Poplar Ridge</i>												
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Ada</i> Middle <i>Marie</i> Last <i>Schanker</i>					<b>4. DATE OF DEATH</b> Month <i>January</i> Day <i>7</i> Year <i>1966</i>												
<b>5. SEX</b> <i>F</i>		<b>6. COLOR OR RACE</b> <i>W</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>August 31 1887</i>		<b>9. AGE</b> (In years last birthday) <i>78</i> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>housewife</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>none</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Baltimore, Md.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>									
<b>13. FATHER'S NAME</b> <i>George Goodrich</i>					<b>14. MOTHER'S MAIDEN NAME</b> <i>Annie Dahl</i>												
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <i>none</i>		<b>17. INFORMANT</b> <i>Edwin Schanker</i> Address <i>same</i>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Stomach</i> (b) <i>Arteriosclerotic coronary heart disease</i> (c) <i>none</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>6 mo.</i> <i>2 years</i>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <i>none</i>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>										
<b>21. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1950</i> to <i>Jan. 7, 1966</i>, that (I) (we) last saw the deceased alive on <i>Jan. 6, 1966</i>, and that death occurred at <i>3 A.M.</i> from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <i>R. M. McLaughlin</i>						<b>22b. DATE SIGNED</b> <i>1/7/66</i>											
<b>22c. PHYSICIAN'S NAME (Type)</b> <i>R. M. McLaughlin, M.D.</i>						<b>22d. ADDRESS</b> <i>3728 Mountair Rd. Pasadena, Md.</i>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>1/10/66</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Glen Haven Memorial</i>		<b>23d. LOCATION (City, town or county) (State)</b> <i>Glen Burnie, Md.</i>											
<b>24. FUNERAL DIRECTOR</b> <i>Kirkley Funeral Home, Glen Burnie, Md.</i>						<b>25a. REC'D BY REGISTRAR</b> <i>IAN 11 1966</i>		<b>25b. REGISTRAR'S SIGNATURE</b>									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

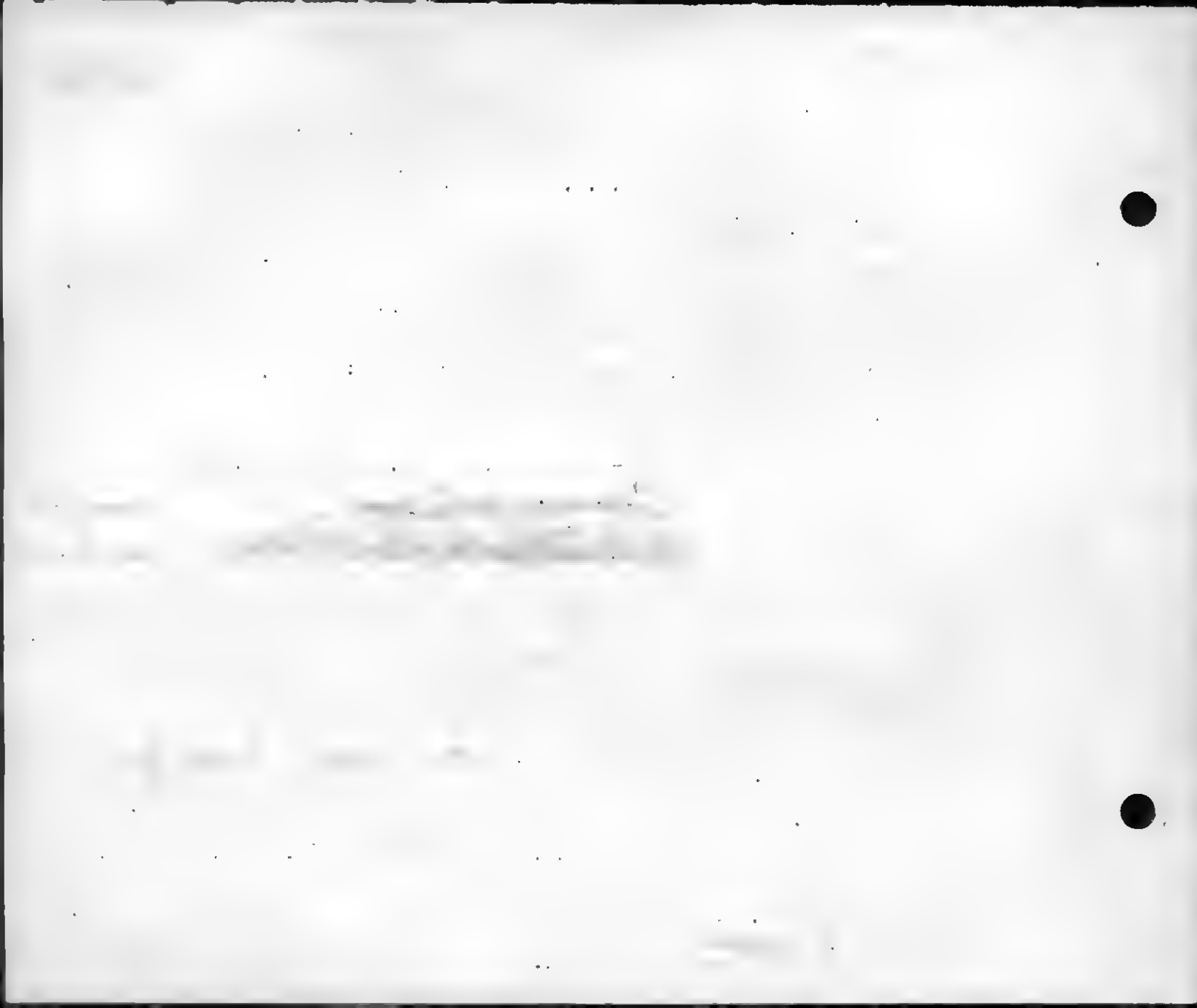
00176

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u> <u>(Dead on arrival)</u>		d. STREET ADDRESS <u>Rt. 2 - Box 25</u>	
3. NAME OF DECEASED (Type or print) First <u>Ervin</u> Middle <u>Ira</u> Last <u>SCHULTZ</u>		4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1911</u>
9. AGE (in years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Designer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George Schultz</u>		14. MOTHER'S MAIDEN NAME <u>Laura Kern</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>181-10-2457</u>	
17. INFORMANT <u>Mrs. Alice B. Schultz same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. AGGIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3</u> , 19 <u>64</u> , to <u>1/30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>January 30</u> , 19 <u>66</u> , and that death occurred at <u>12:10 p.m.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>2/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 5, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hills Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Philadelphia, Pa.</u>
24. FUNERAL DIRECTOR <u>HOPPING FUNERAL HOME</u>		25a. REG'D BY REGISTRAR <u>FEB 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and by any event, within 72 hours after death.

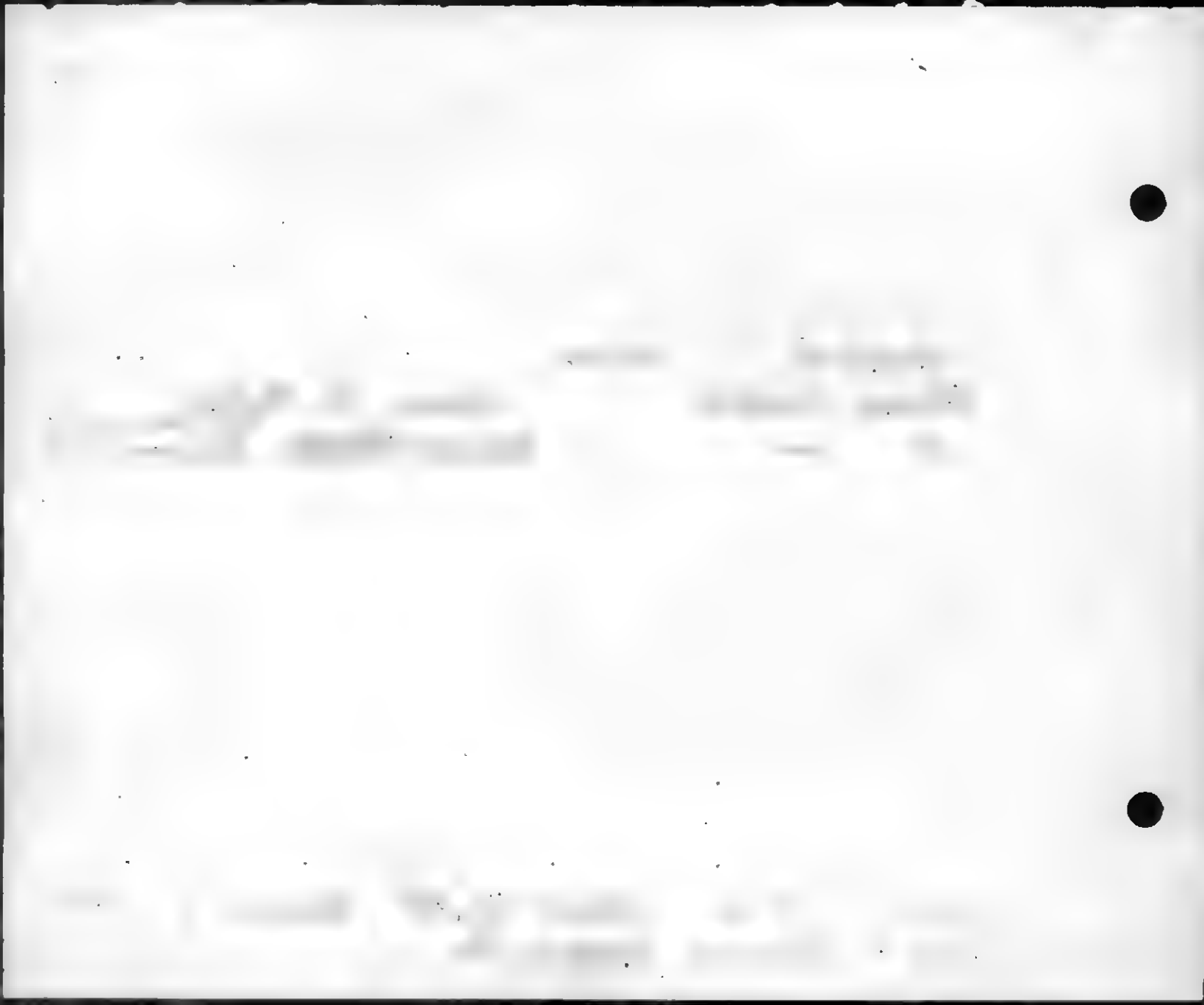


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>						c. LENGTH OF STAY IN 1b <u>Annapolis</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>						d. STREET ADDRESS <u>16 Murray Ave.,</u>					
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Virginia</u> Last <u>SHORTT</u>						4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 9, 1879</u>		9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>THOMAS CARROLL</u>						14. MOTHER'S MAIDEN NAME <u>FRANCES A. MULLEN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>—</u>					
17. INFORMANT <u>FRANCES McCARTER</u>						18. ADDRESS <u>1435 SPRINGVIEW AVE ANNAPOLIS, MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>IX</u> DUE TO (c) <u>—</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <u>Richard I. Hochman</u> attended the deceased from <u>1/12</u> , 19 <u>66</u> , to <u>Jan. 14</u> , 19 <u>66</u> , that (2) <u>—</u> last saw the deceased alive on <u>Jan. 14</u> , 19 <u>66</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard I. Hochman</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>						22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>1-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BUSH</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR &amp; SONS</u>						ADDRESS <u>ANNAPOLIS, MD.</u>		25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00180

## CERTIFICATE OF DEATH

Item #9 Film #G373 7/19/66

00173

1. PLACE OF DEATH a. COUNTY <u>A. A.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>MD</u> f. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>74 College Ct. Terrace</u>		e. STREET ADDRESS <u>74 College Ct. Terrace</u>	
3. NAME OF (Type or print) <u>Harriet Simon</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refined</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		14. SOCIAL SECURITY NO. <u>213-322623</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to Arterio-sclerosis</u> (c) <u>Hypertensive Cardiovascular disease</u>		16. INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1966</u> to <u>1/19/66</u> that (I) (we) last saw the deceased alive on <u>1/19/66</u> and that death occurred at <u>11:22 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. R. Richardson</u>		22b. DATE SIGNED <u>1/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. R. Richardson</u>		22d. ADDRESS <u>110 - 4th St Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-22-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>JAN 24 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00181

00174

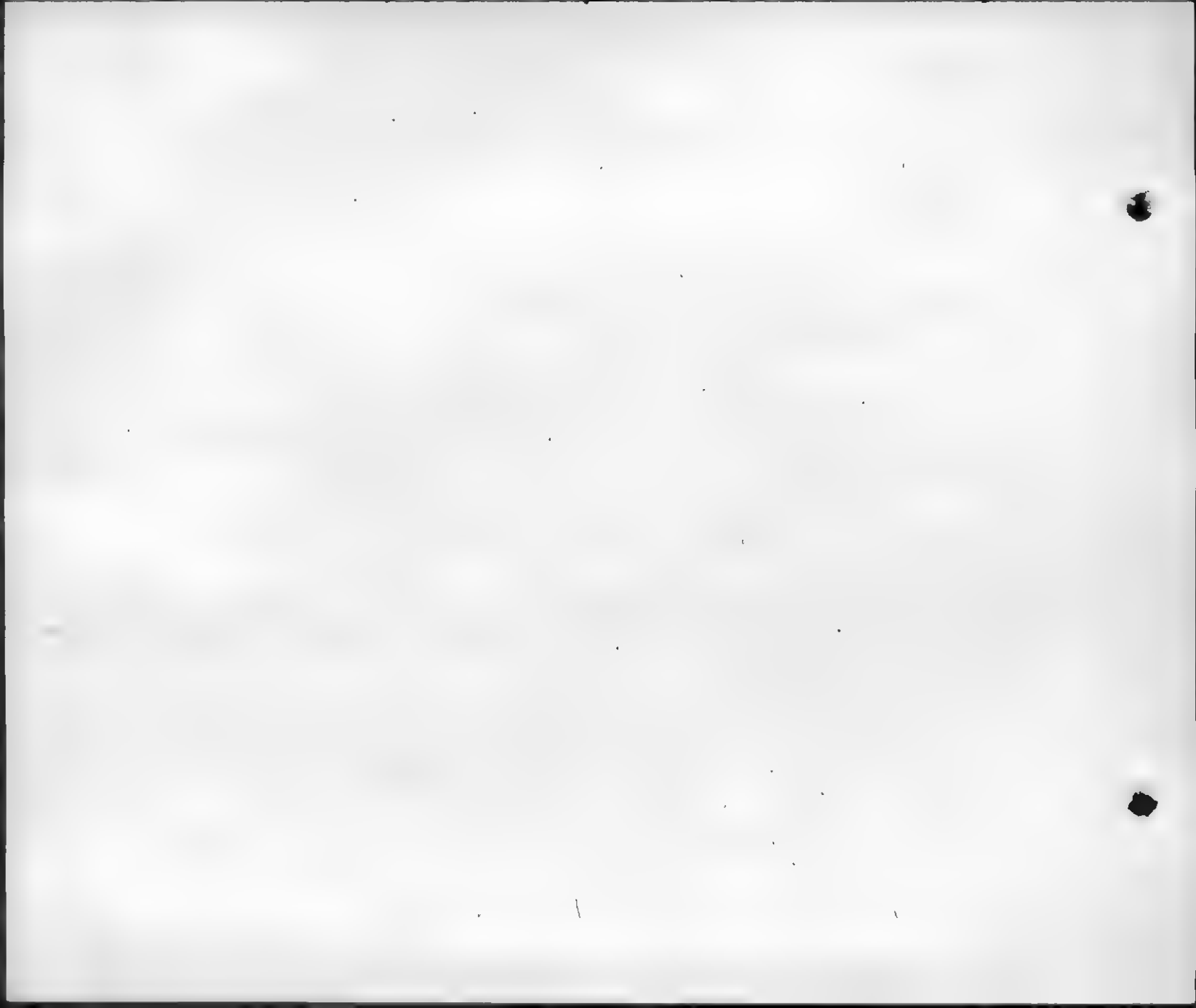
1. PLACE OF DEATH a. COUNTY <b>ANNE ARUN DEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rt 9, Box 260 02-1</b>	
c. LENGTH OF STAY IN 1b <b>39 years</b>		d. STREET ADDRESS <b>Pasadena, MD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rt 9, Box 260 - Pasadena, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>HENRY</b> Last <b>SIMONDS</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>19</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 MARCH 1983</b>
9. AGE (in years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST-RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>YES (USA)</b>		13. FATHER'S NAME <b>RICHARD SIMONDS (dec)</b>	
14. MOTHER'S MAIDEN NAME <b>LAURA ROBINSON (dec)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>215-03-0885</b>		17. INFORMANT <b>Mrs. Alice G. Bowen - Same address - (sister in law)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>FIX</b> (b) <b>CHRONIC ASTHMA-EMPHYSEMA</b> (c) <b>20 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTHRITIS - DIVERTICULITIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no accident</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>—</b> e.m. <b>—</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>65</b> , to <b>present</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-16</b> , 19 <b>65</b> , and that death occurred at <b>1<sup>st</sup></b> A.M. from the causes and on the date stated above.	
22a. SIGNATURE <b>H.F. Manuzak</b> M.D.		22b. DATE SIGNED <b>19 January 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.F. MANUZAK, M.D.</b>		22d. ADDRESS <b>425 S. RITCHIE HWY, GLEN BURNIE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-21-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK CEM</b>		23d. LOCATION (City, town or county) (State) <b>BALTO MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chowell</b> ADDRESS <b>3615 Chestnut Ave</b>		25a. REC'D BY REGISTRAR <b>JAN 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Carter Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and 5 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION







1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00183

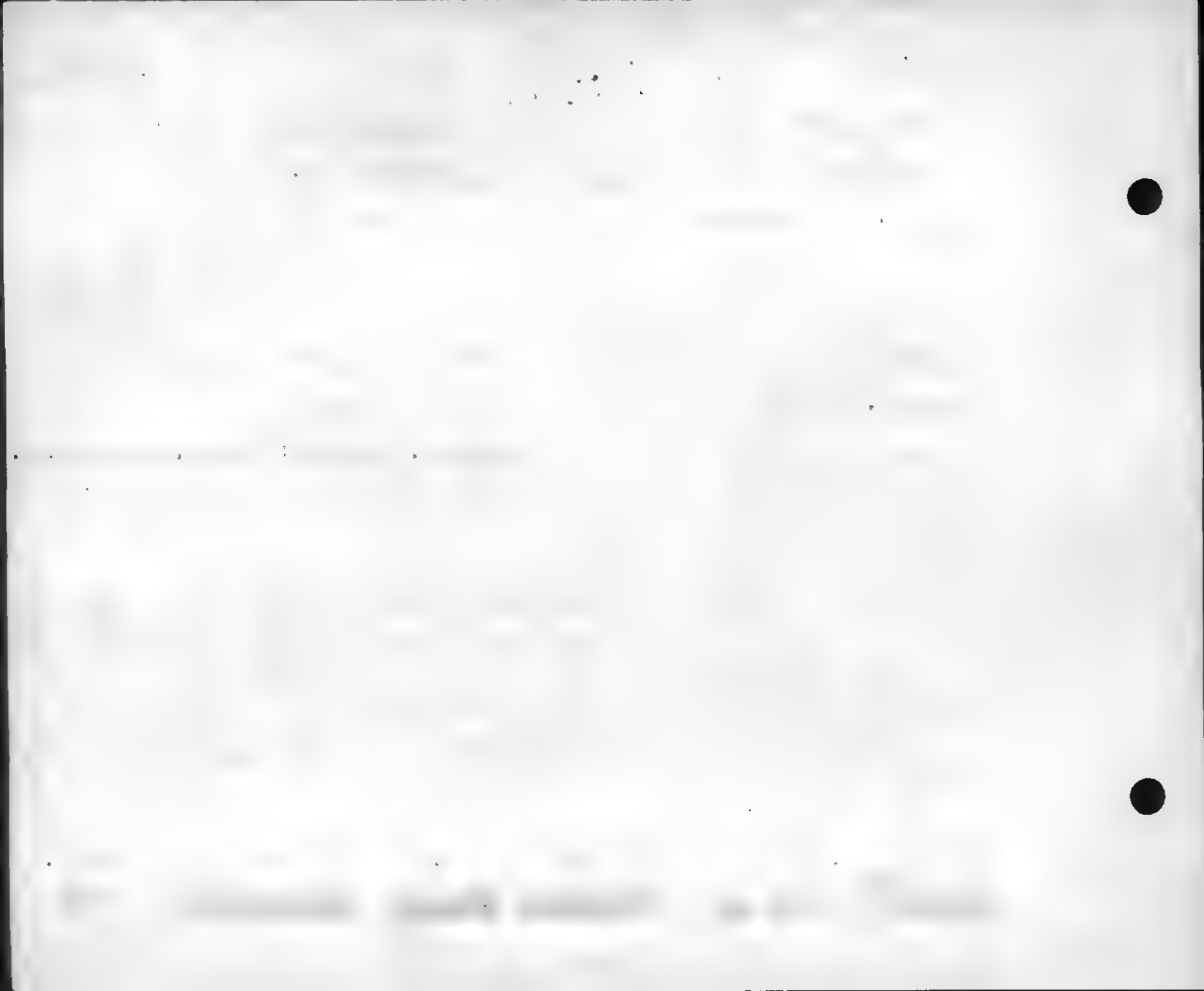
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00176

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Md.</b> d. STREET ADDRESS <b>Annapolis, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby boy</b> First Middle Last <b>Soledad</b>		4. DATE OF DEATH Month Day Year <b>January 23 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 January 66</b>
9. AGE (In years last birthday) <b>2</b> yrs. <b>19</b> Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis Anne Arundel, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Felipe T. Soledad</b>	
14. MOTHER'S MAIDEN NAME <b>Sharon GEARY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Felipe T. Soledad 519 2nd St. Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>23 January, 1966</b> to <b>23 January, 1966</b> , that (I) (we) last saw the deceased alive on <b>23 January 1966</b> , and that death occurred at <b>1420X</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. L. Gaudry</b>		22b. DATE SIGNED <b>24 January 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. L. GAUDRY, LT, MC, USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-26-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>U.S. NAVAL ACADEMY</b>	23d. LOCATION (City, town or county) (State) <b>ANNAPOLIS MD.</b>
24. FUNERAL DIRECTOR <b>John M. Taylor San Annapolis Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 2 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

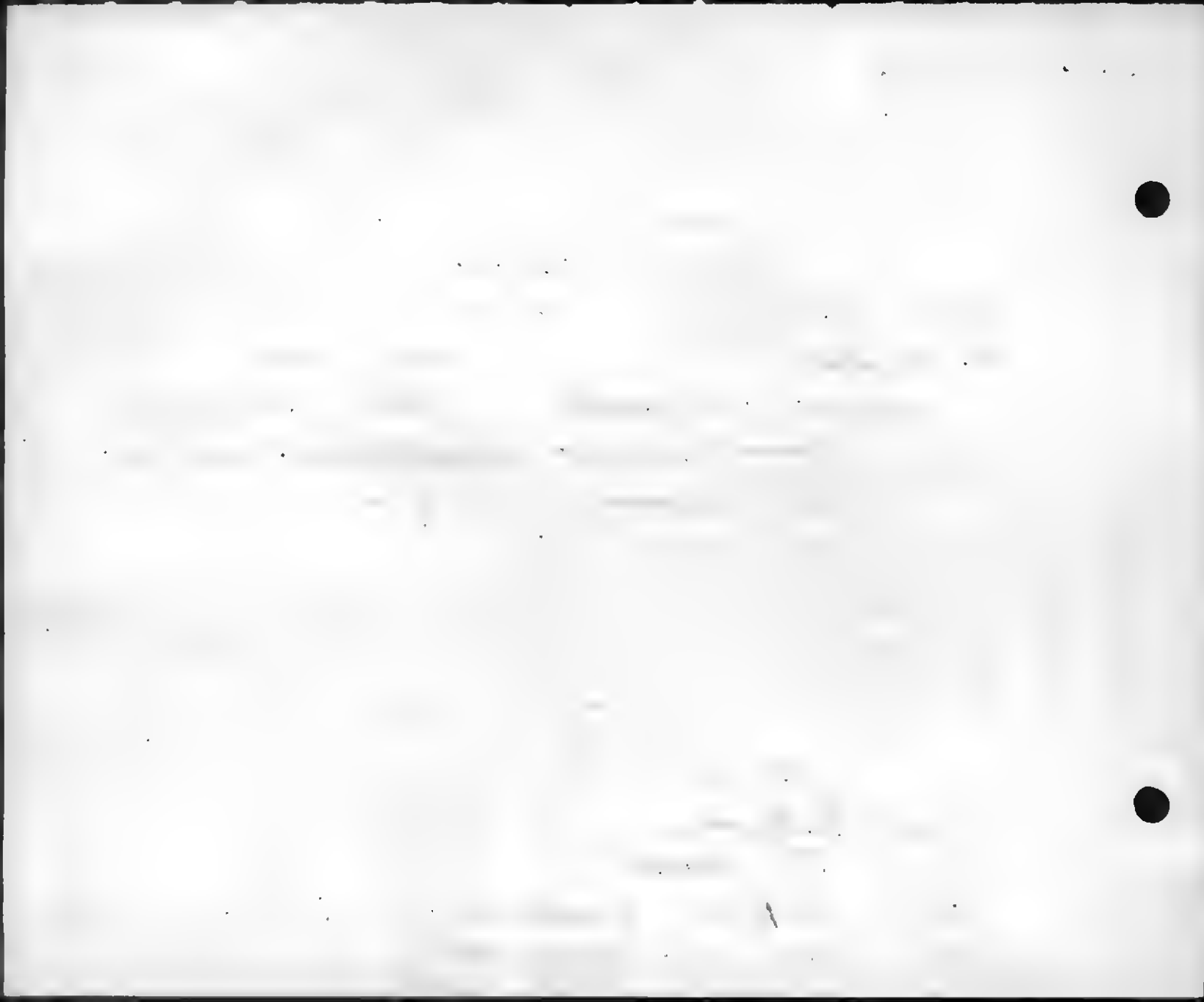
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00184

00177

1. PLACE OF DEATH a. COUNTY <u>AA CO</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPR BURNIE</u>		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA-NORTH ACUNDEL Hosp.</u>		d. STREET ADDRESS <u>Rt 7-Box 370</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George W. Steinmann</u>		4. DATE OF DEATH Month Day Year <u>1 28 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/10/54</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Toil &amp; Die MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>York, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Adolph Steinmann</u>		14. MOTHER'S MAIDEN NAME <u>MARY Neidhardt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-08-6425</u>	
17. INFORMANT <u>Mr. Ronald Strohecker</u>		Address <u>101 Mt. Desats Rd. BALTO. 29, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiomyopathy</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhorst</u> NAME (Type)		22. DATE SIGNED <u>1-28-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Feb 3, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Louder Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>		25a. REC'D BY REGISTRAR <u>Feb 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>			

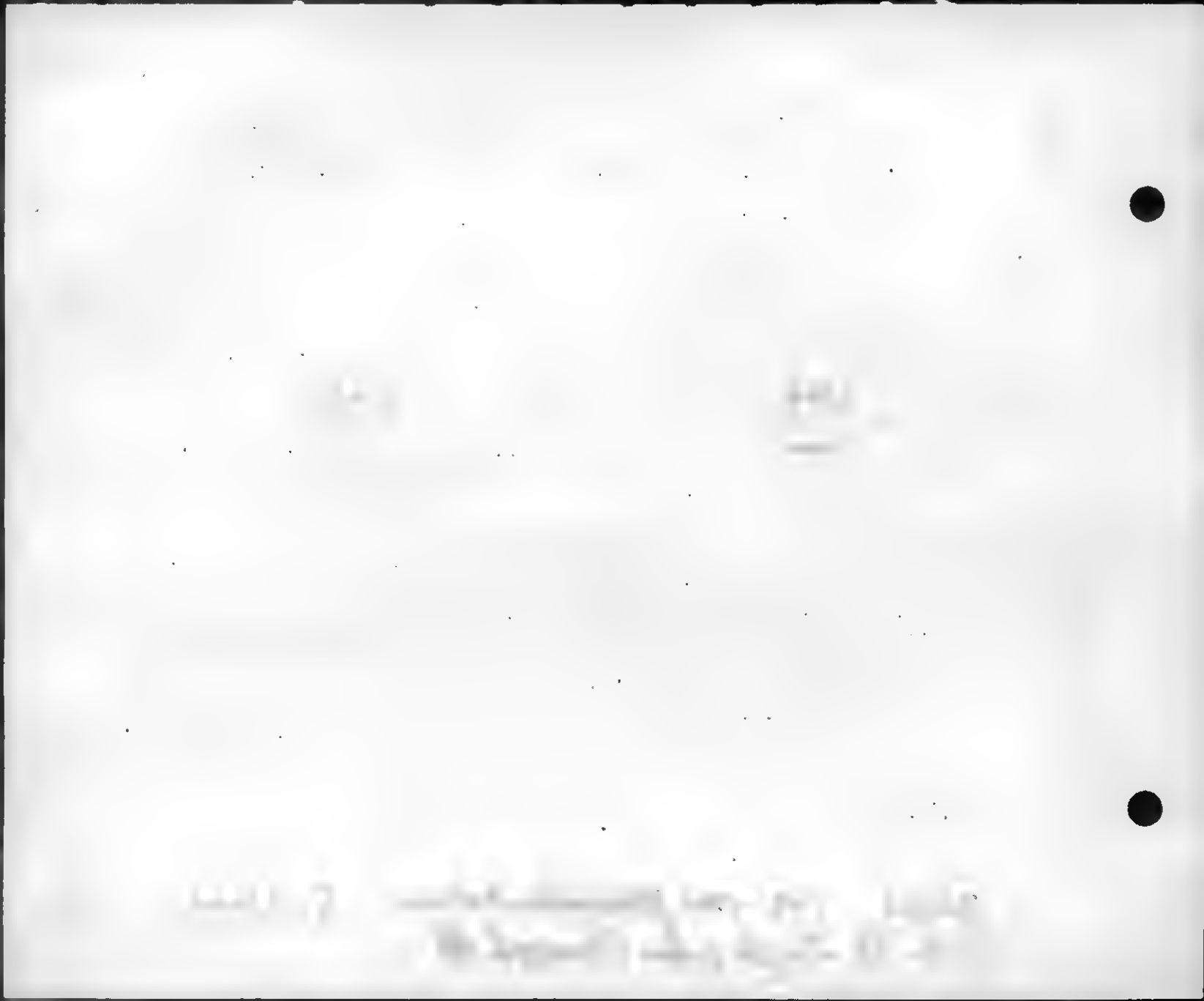


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Then~~ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>00185</span> <span>CERTIFICATE OF DEATH</span> <span>00178</span> </div>											
1. PLACE OF DEATH a. COUNTY <b>Annapolis</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN ID <b>88 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> , last <b>1½ yrs</b> ; b. COUNTY <b>Anne Arundel Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mayo - Edgewater P.O.</b> d. STREET ADDRESS <b>Rt. 1, Box 306-F</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Annie Irene Stickell</b>			4. DATE OF DEATH Month <b>1</b> Day <b>28</b> Year <b>1966</b>								
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-16-86</b>		9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Near Reading, Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>"Unk."</b>					14. MOTHER'S MAIDEN NAME, <b>"Unk."</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Mrs. Grace Proctor, (dau)</b>			Address <b>Same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <b>Dehydration &amp; toxicity</b> DUE TO (c) <b>Extensive decubiti; (d) ere, supracondylar, left</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus of 8 years' known duration</b> <b>Post-op infection, operative wound, practically subsided, Senility.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10 days</b> <b>88 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Notified</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fell in her home</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:30 a.m.</b> p.m. <b>11/2 1965</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Mayo</b> (County) <b>Anne Arundel</b> (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 2, 1965</b> , to <b>Jan. 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan. 20, 1966</b> , and that death occurred at <b>6:55 M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Harold R. Bohlman</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/28/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>HAROLD R. BOHLMAN, M.. D.</b>					22d. ADDRESS <b>96 Cathedral St., Annapolis, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>1-31-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>			23d. LOCATION (City, town or county) <b>Suitland</b> (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>John M. Layla + Sons Annapolis, Md.</b>					ADDRESS <b>---</b>		25a. REC'D BY REGISTRAR <b>FEB 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James J. J.</b>		

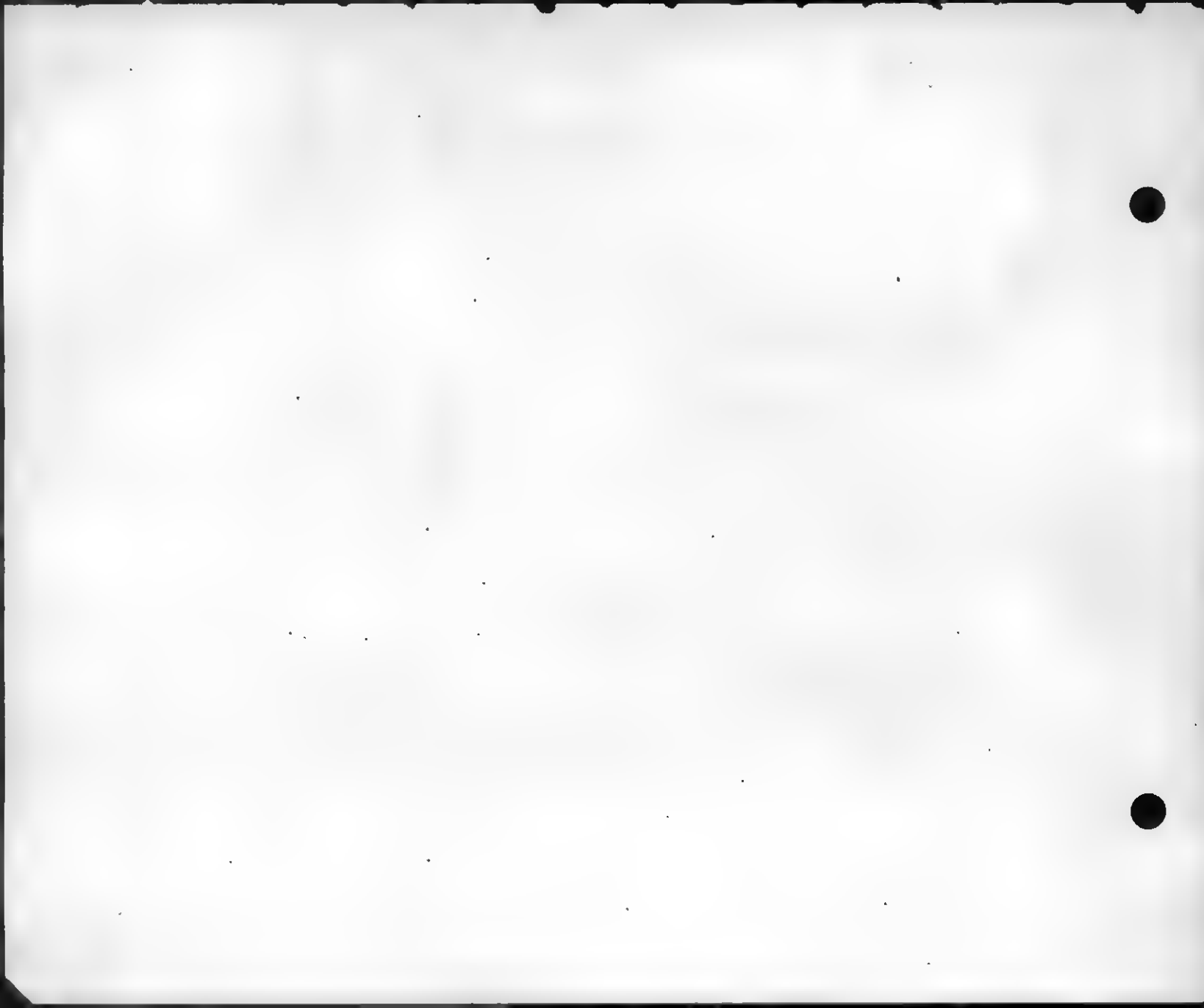


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

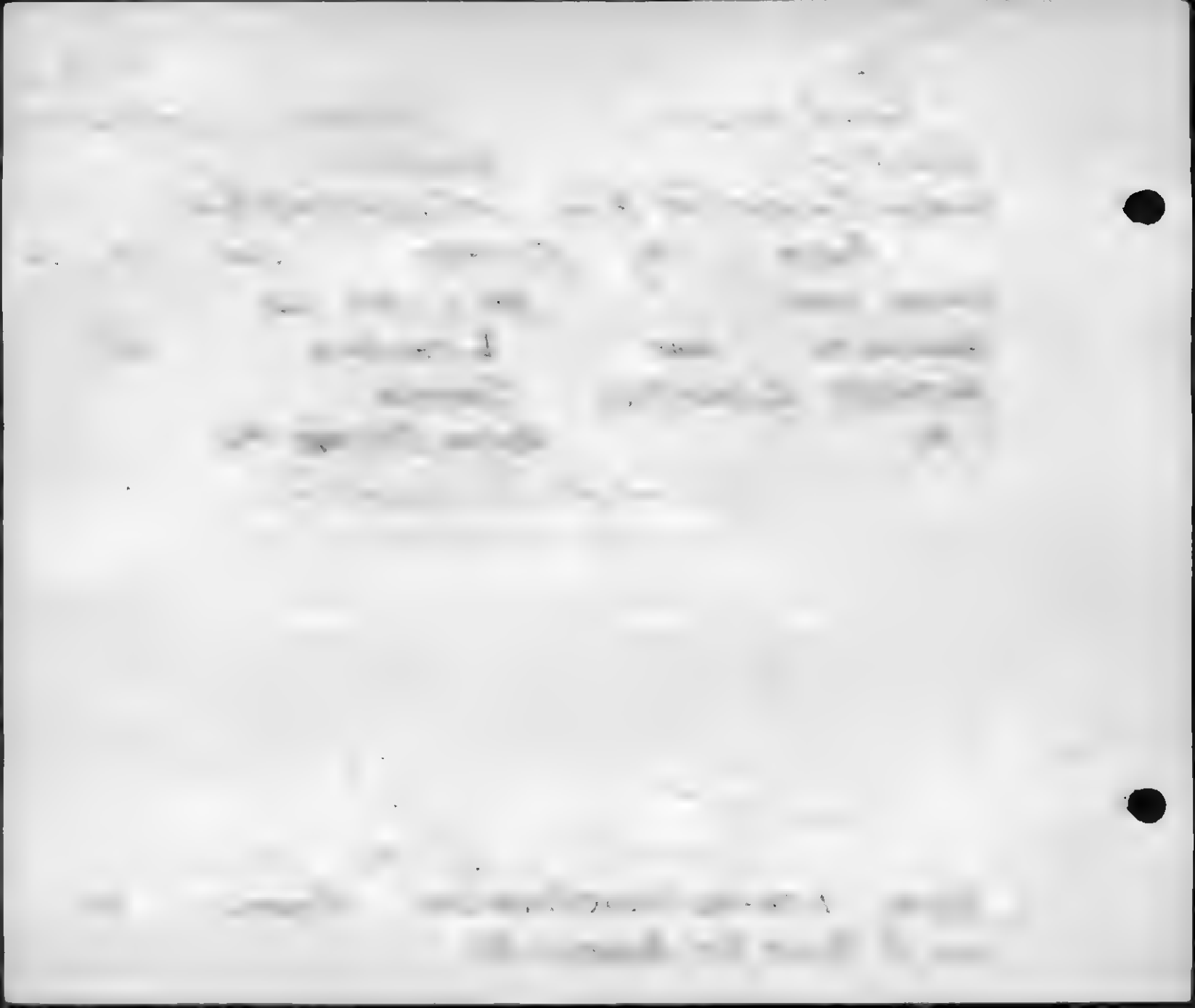
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>CROWNSVILLE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN ID	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>CROWNSVILLE STATE HOSPITAL</b>		e. STREET ADDRESS <b>4625 KAVON AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>MARY SWAN</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/1889</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
14. FATHER'S NAME <b>William Beatley</b>		15. MOTHER'S MAIDEN NAME <b>unknown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Edward B. Swan</b>		Address <b>4624 Kavon Ave. 21206</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> DUE TO <b>MYOCARDIAL DAMAGE</b> (b) <b>DIABETES MELLITUS</b> DUE TO <b>LOBAR PNEUMONIA</b> (c) <b>SCIZOPHRENIC REACTION, UNDIFFERENTIATED TYPE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-11-1966</b> to <b>1-29-1966</b> that (I) (we) last saw the deceased alive on <b>1-29-1966</b> and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. BENEDICT M.D.</b>		22b. DATE SIGNED <b>2/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>		22d. ADDRESS <b>Crownville State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1 Feb. 66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home, Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			



Item 18 Film G373 373 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00187 00180  
27 17 30 11  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ANNAPOLIS CONVALESCENT HOME</b>		d. STREET ADDRESS <b>115 CHESAPEAKE AVE</b>	
3. NAME OF DECEASED (Type or print) <b>ANNA M SYCHUK</b>		4. DATE OF DEATH <b>JAN 22 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 11 1903</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>ANTHONY ZEMAITIS</b>		14. MOTHER'S MAIDEN NAME <b>THERESA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>MICHEL SYCHUK #2</b>	
17. INFORMANT <b>MICHEL SYCHUK #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>1751</b> Conditions, if any, which gave rise to immediate cause (b) <b>Primary Carcinoma Fallopian tube, abdominal</b> (c), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 22</b> , 1966, to <b>Jan 22</b> , 1966, that (I) (we) last saw the deceased alive on <b>Jan 22</b> , 1966, and that death occurred at <b>11:22</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Linhardt</b>		22b. DATE SIGNED <b>1-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Linhardt</b>		22d. ADDRESS <b>Chesapeake</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-26-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF CEM.</b>	23d. LOCATION (City, town or county) (State) <b>ANNAPOLIS MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR SONS</b>		25a. REC'D BY REGISTRAR <b>JAN 25 1966</b>	
ADDRESS <b>ANNAPOLIS MD.</b>		25b. REGISTRAR'S SIGNATURE	

TO POSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



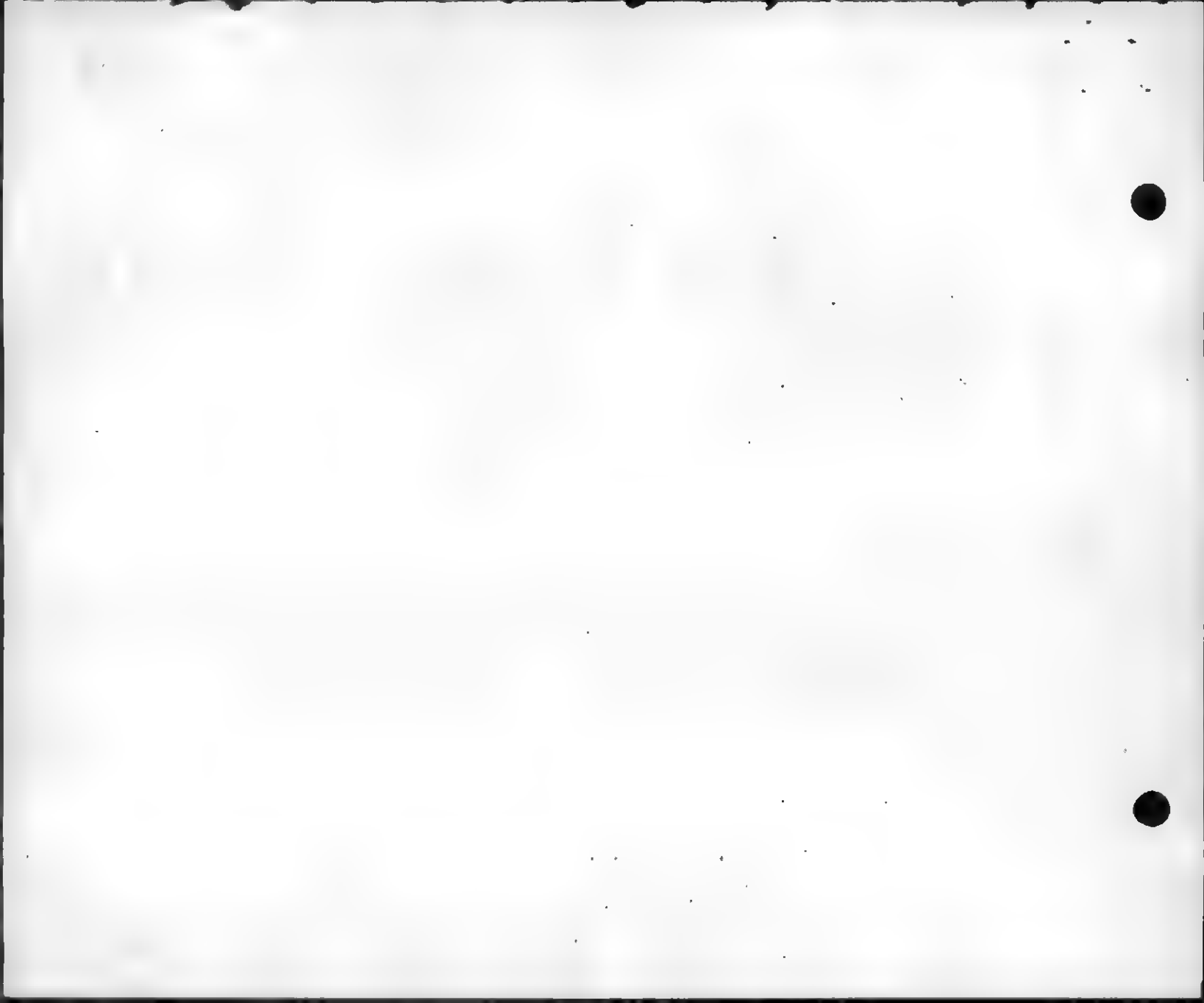


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div> <div>1.</div> <div> <div>00188</div> <div>00182</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				d. STREET ADDRESS <u>Box 302-E (Rt 11)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Gen'l. Hospital</u>											
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>D.</u> Last <u>Thompson</u>			4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1966</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 March 1962</u>		9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Dewey C. Thompson - Jr.</u>						14. MOTHER'S MAIDEN NAME <u>Mary Wheat</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dewey C. Thompson - Jr. (Father)</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis (Pneumo)</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>3d.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Mental Retardation</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 22</u> , 19 <u>65</u> , to <u>Jan 7</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>1-7</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert C. Irwin M.D.</u>								22b. DATE SIGNED <u>1-11-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Irwin M.D.</u>								22d. ADDRESS <u>5550 Baltimore National Pike, Balt.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/13/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie Md.</u>					
24. FUNERAL DIRECTOR <u>Robert Pivara</u>						25a. REC'D BY REGISTRAR <u>Jan 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00189

00181

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>211 Duke of Gloucester St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <b>Edna S. THOMPSON</b>		4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1966</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1894 March 10, 1905</b>		9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS. Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>EDWIN SPEAR</b>								14. MOTHER'S MAIDEN NAME <b>LUCY HURTT</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>-</b>				17. INFORMANT <b>THOMAS S THOMPSON #2</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4:01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																INTERVAL BETWEEN ONSET AND DEATH <b>1 hr -</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) <del>was not</del> attended the deceased from <b>1-28-66</b> to <b>1-28-66</b> , that (I) <del>was</del> last saw the deceased alive on <b>January 28, 1966</b> , and that death occurred at <b>4:15 p.m.</b> from the causes and on the date stated above.																	
22a. SIGNATURE <b>Frank M. Shipley</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED <b>2-1-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Frank M. Shipley, M.D.</b>								22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2-4-66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF CEM.</b>				23d. LOCATION (City, town or county) (State) <b>ANNAPOLIS MD.</b>					
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR SONS ANNAPOLIS MD.</b>								25a. REC'D BY REGISTRAR <b>Feb 7 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1911

THEY WILL  
BE WITH US

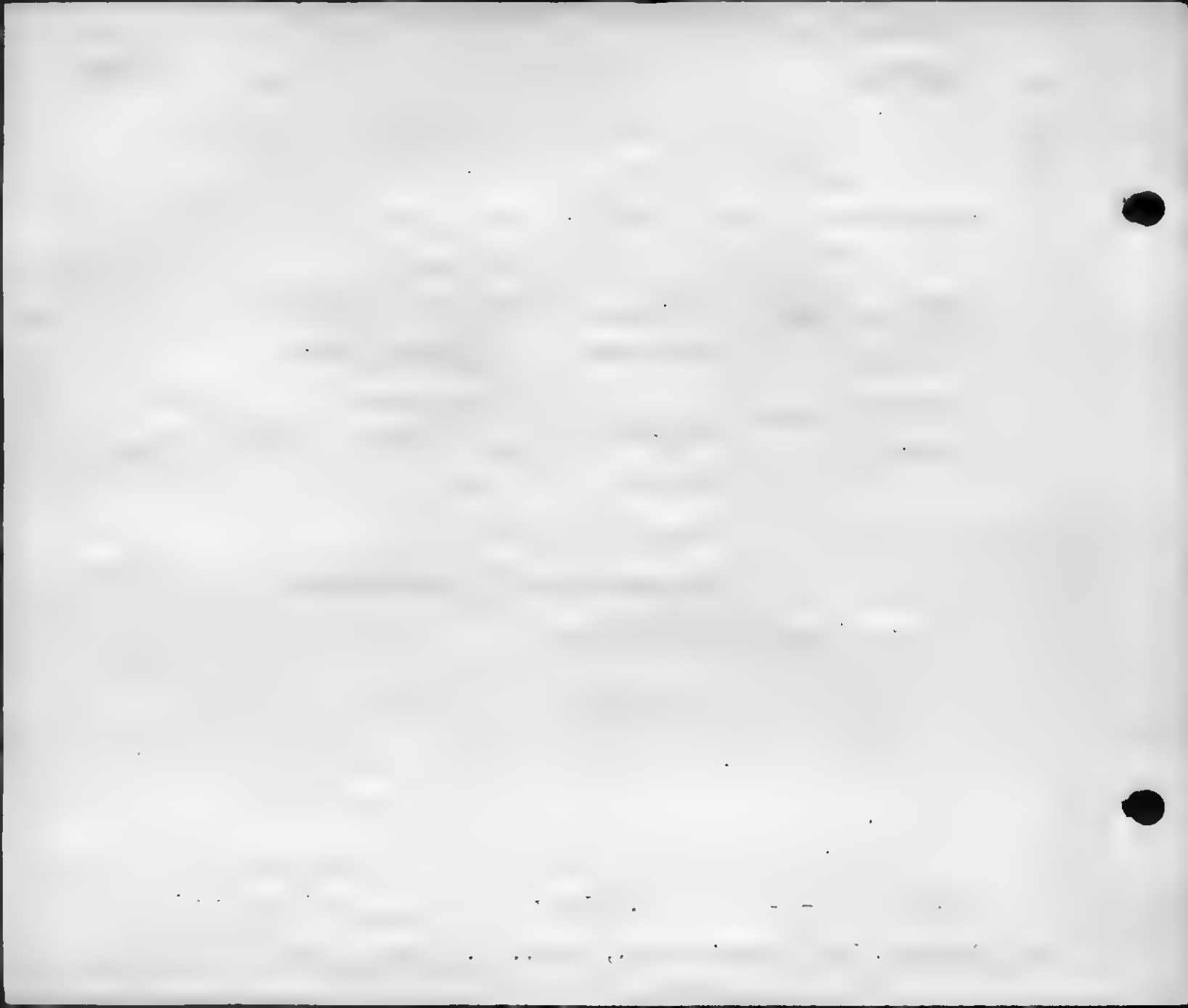
THEY WILL  
BE WITH US

1911

THEY WILL  
BE WITH US

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesapeake, Md.</i>		c. LENGTH OF STAY IN 1b <i>7 months</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Md.</i>		f. COUNTY <i>Anne Arundel</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Moses</i>		4. DATE OF DEATH Day <i>1</i> Month <i>19</i> Year <i>1966</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Day <i>1886</i> Month <i>80</i> Year <i>80</i>	
9. AGE (In years last birthday) <i>80</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Southern State</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>420-07-5085</i>		17. INFORMANT <i>Janet Major</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>ASCVD - CHF</i> (a), stating the underlying cause last (c) <i>Chronic Bronchitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several hrs.</i> <i>Unknown</i> <i>Unknown</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-22-1965</i> to <i>1-19-1966</i> , that (I) (we) last saw the deceased alive on <i>1-19-1966</i> , and that death occurred at <i>11:13</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Richard H. Hunt</i>		22b. DATE SIGNED <i>1-19-66</i>		22c. PHYSICIAN'S NAME (Type) <i>RICHARD H. HUNT</i>		22d. ADDRESS <i>100 Cherry Lane, Glen Burnie, Md.</i>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-21-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		24b. ADDRESS <i>802 Madison Ave., Balto., Md.</i>	
25a. REC'D BY REGISTRAR <i>JAN 21 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John L. Judge</i>		25c. DATE <i>JAN 21 1966</i>		25d. TIME <i>10:00</i>		25e. PLACE <i>Baltimore, Md.</i>		25f. OTHER <i></i>	



Item 18 Film G373 2/21/66  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH** 00184

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b> d. STREET ADDRESS <b>133 Brent</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eugene Randolph TYNER</b>		4. DATE OF DEATH Month Day Year <b>January 24 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, 1924</b>
9. AGE (In years last birthday) <b>41 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>11 11 11 11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard, Security Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tampa, Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Tyner</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>26516368</b>	
17. INFORMANT <b>Mrs Gloria Tyner (Wife)</b>		Address <b>133 Brent Arnold, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending/ Acute congestive heart failure</b> 4551 DUE TO <b>Cardiac arrhythmia?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>R.R. Brock, LCDR MC USN</b>		22b. DATE SIGNED <b>25 Jan. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.R. Brock, LCDR MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>1-28-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda National</b>		23d. LOCATION (City, town or county) (State) <b>Bethesda Md</b>	
24. FUNERAL DIRECTOR <b>Charles J. Baranowski</b>		25a. REC'D BY REGISTRAR <b>1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Remains cleared by County Coroner Dr. Linhart

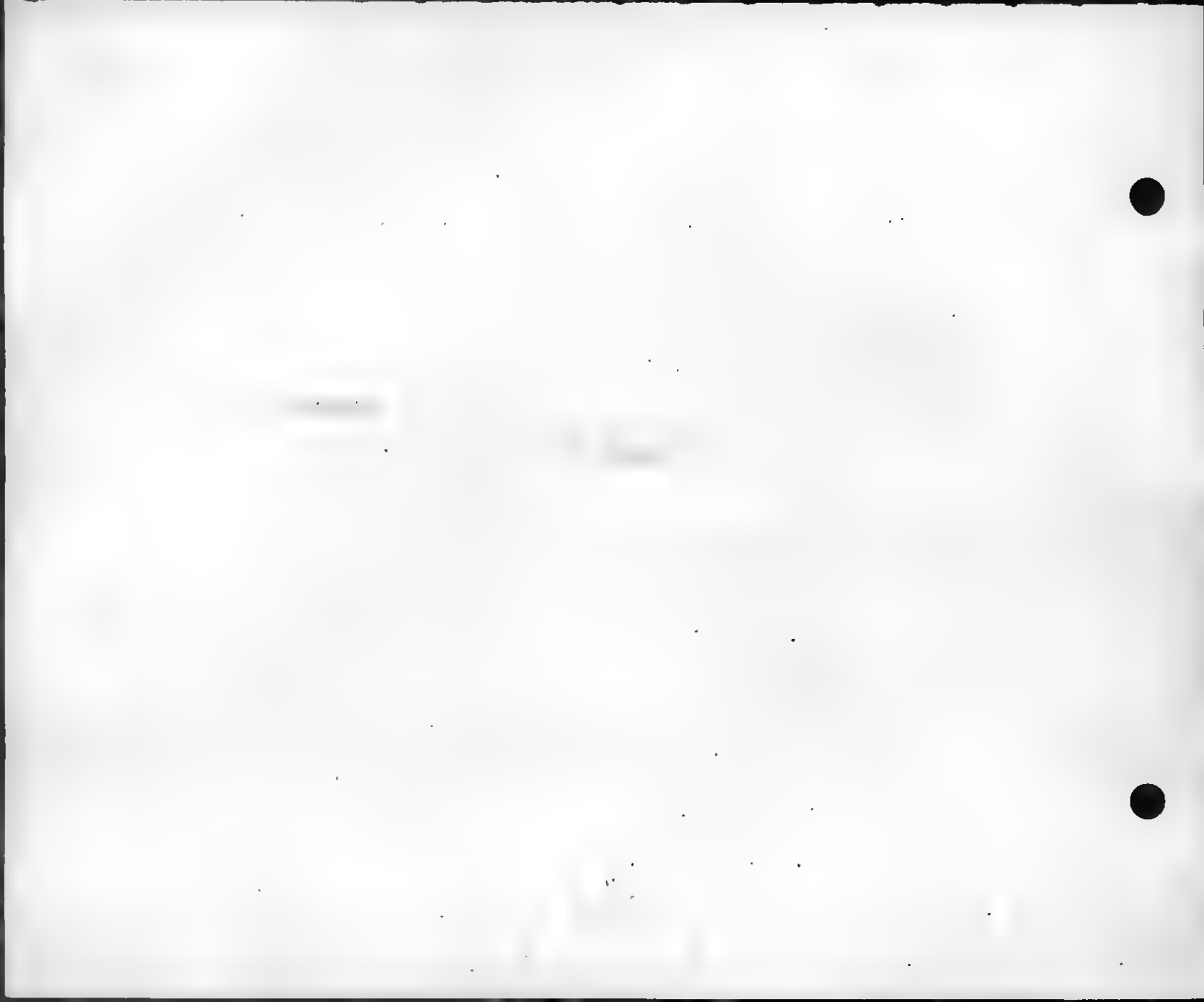
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00192				CERTIFICATE OF DEATH				00185			
1. PLACE OF DEATH a. COUNTY Anne Arundel County						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownville				c. LENGTH OF STAY IN 1b 1 mo. 13 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownville State Hospital						d. STREET ADDRESS 1711 St. Paul Street (2)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence			Middle M.			Last Lindernhill			4. DATE OF DEATH Month 1 Day 18 Year 1965		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/26/11		9. AGE (in years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME T. Thomas						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 513-18-4457		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) In addition. Multiple Decubiti											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/5/1965, to 1/18/1966, that (I) (we) last saw the deceased alive on 1/13/1966, and that death occurred at 1:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						22b. DATE SIGNED 1/18/66		22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-20-66		23c. NAME OF CEMETERY OR CREMATORY Belle Harbor		23d. LOCATION (City, town or county) (State) Belle Harbor Md		24. FUNERAL DIRECTOR John J. Conaway & Son Inc, Belle Harbor		25a. REC'D BY REGISTRAR JAN 20 1966	
										25b. REGISTRAR'S SIGNATURE [Signature]	



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20M 1/65

BP

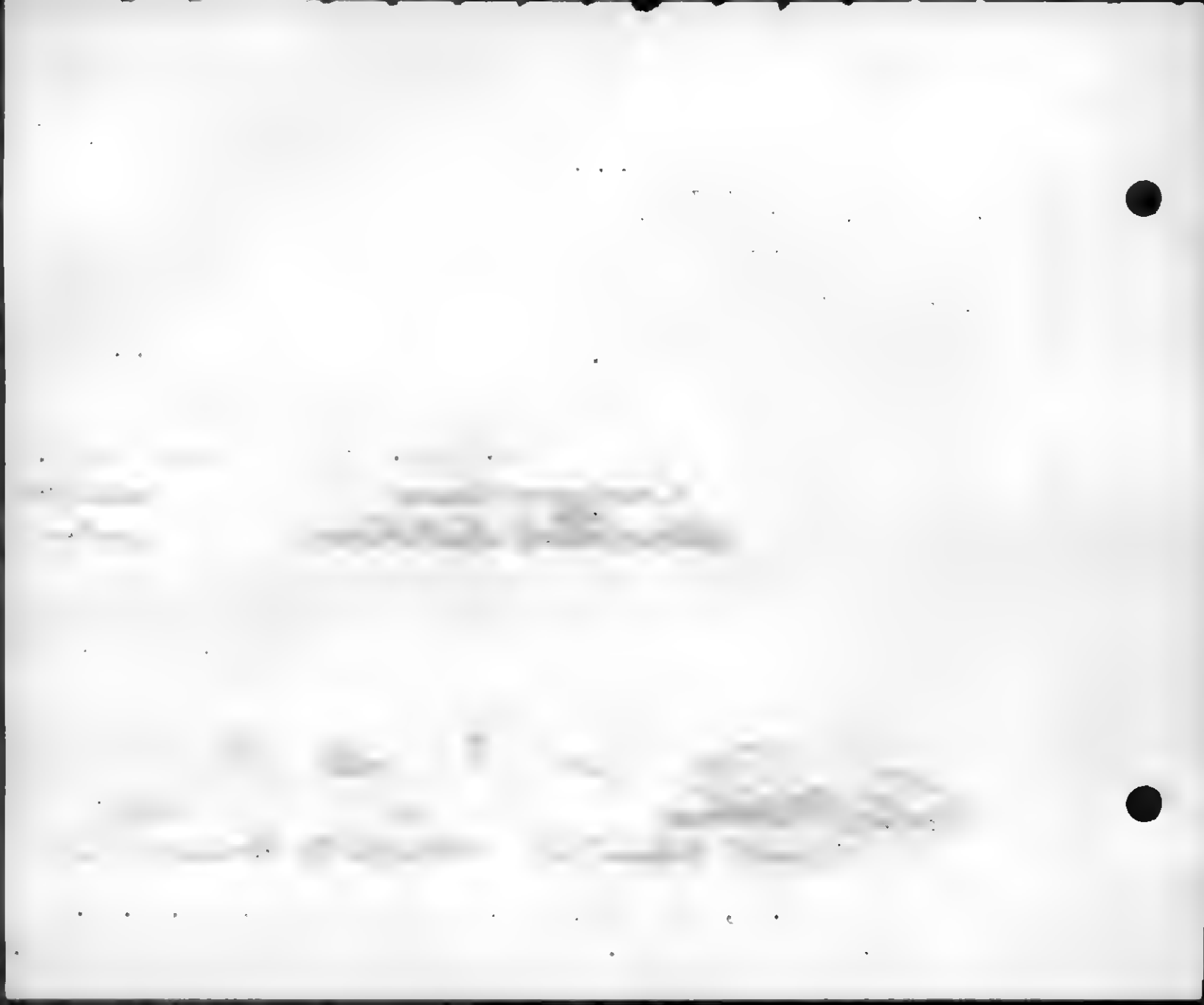
00193

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00186

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Baltimore</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>466 Carvel Beach Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Anthony</u> Last <u>WAGNER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1909</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Mary K. Wagner</u>		Address <u>466 Carvel Beach Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 42-1 DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>7</u> , 19 <u>65</u> , to <u>1/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/31</u> , 19 <u>65</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard I. Hochman</u>				22b. DATE SIGNED <u>1/10/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>				22d. ADDRESS <u>59 Franklin St. Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn, A. A. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Mc Cully</u>		ADDRESS <u>130 E. Fort Ave</u>		25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Walter Judge</u>	

DATE JAN 11 1966



1  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00194

00187

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		d. STREET ADDRESS <b>RTE. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b>		4. DATE OF DEATH Month <b>1</b> Day <b>24</b> Year <b>1966</b>		5. SEX <b>male</b>	
6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 25, 1948</b>	
9. AGE (In years last birthday) <b>18</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>24</b>		11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drill Machine Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry - Wells</b>		11. BIRTHPLACE (State or foreign country) <b>Gambrills, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William M. Warfield</b>		14. MOTHER'S MAIDEN NAME <b>Alice E. Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-46-9992</b>		17. INFORMANT <b>Wm. M. Warfield (father)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4148</b> DUE TO <b>Electrocution</b> Conditions, if any, which gave rise to immediate cause (b) <b>(a), stating the underlying cause last.</b> DUE TO <b>(c)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>was lowering drilling apparatus and boom struck overhead tension wires</b>			
20c. TIME OF INJURY Month, Day, Year <b>1:30 a.m. 1 24 1966</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>field</b>	
20f. (City or town) <b>Severn</b>		20g. (County) <b>A.A.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/25/66</b>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 28, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	
22d. LOCATION (City, town, or country) <b>Washington, D.C.</b>		22e. (State) <b>D.C.</b>		22f. (Country) <b>U.S.A.</b>	
23. FUNERAL DIRECTOR <b>R. V. Singleton</b>		23a. ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>		23b. REC'D BY REGISTRAR <b>JAN 28 1966</b>	
23c. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		23d. (City, town, or country) <b>Glen Burnie, Md.</b>		23e. (State) <b>Md.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

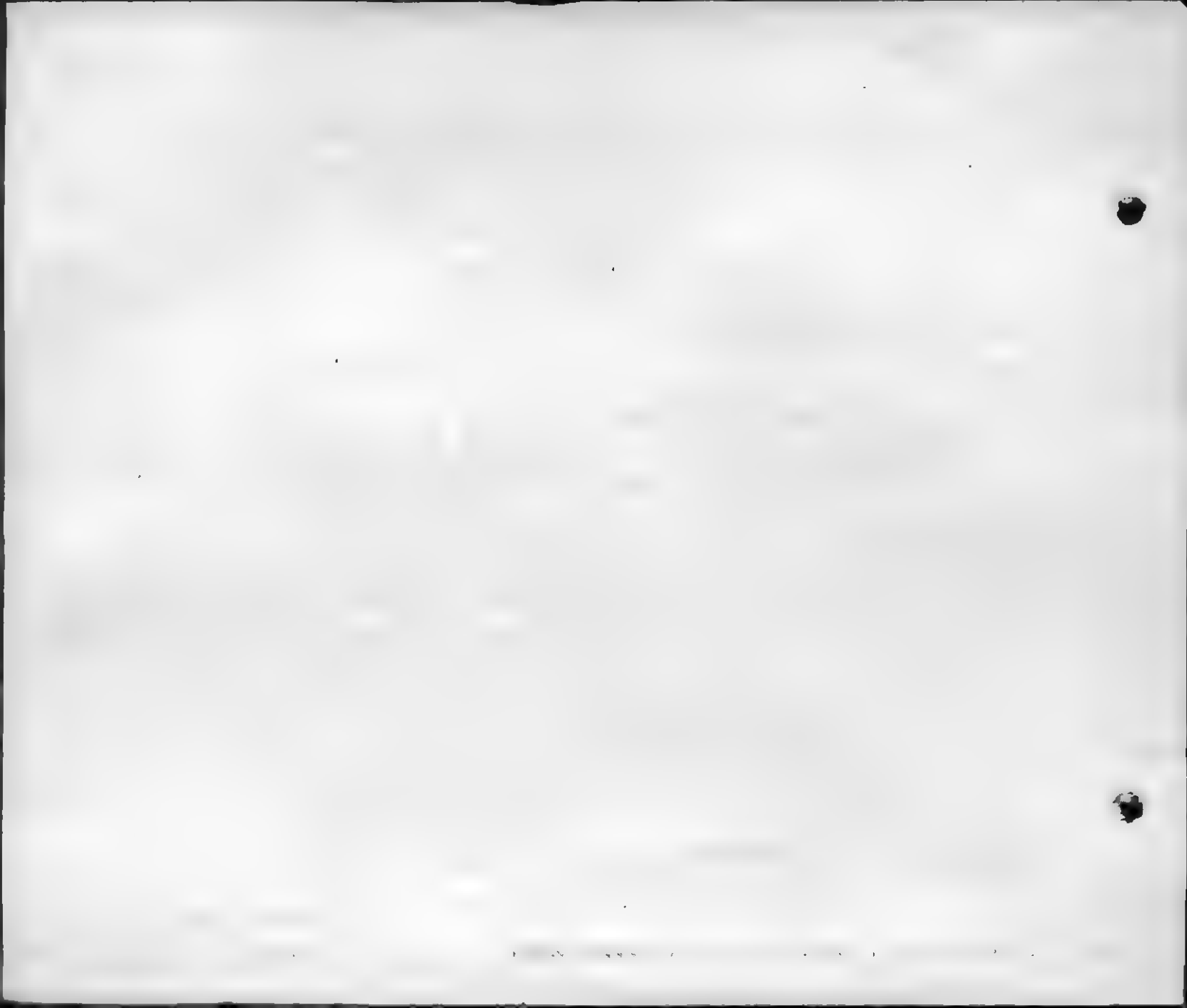
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/62

00195  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00188

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tracy's Landing</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tracy's Landing</u> d. STREET ADDRESS		3. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carl B. Washington</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>1 31 1966</u>			
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/19/1965</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>21</u> Days <u></u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Chilverly, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Guy E. Washington</u>		14. MOTHER'S MAIDEN NAME <u>Dean M. Barnett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Guy E. Washington - Shadyside, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute upper respiratory infection</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (e), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. L. [Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1.31.66.</u>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>	
22d. LOCATION (City, town, or country) <u>Shadyside, Md.</u>		(State)			
23. FUNERAL DIRECTOR <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u>	
DATE <u>FEB 7 1966</u>		<u>152798</u>			



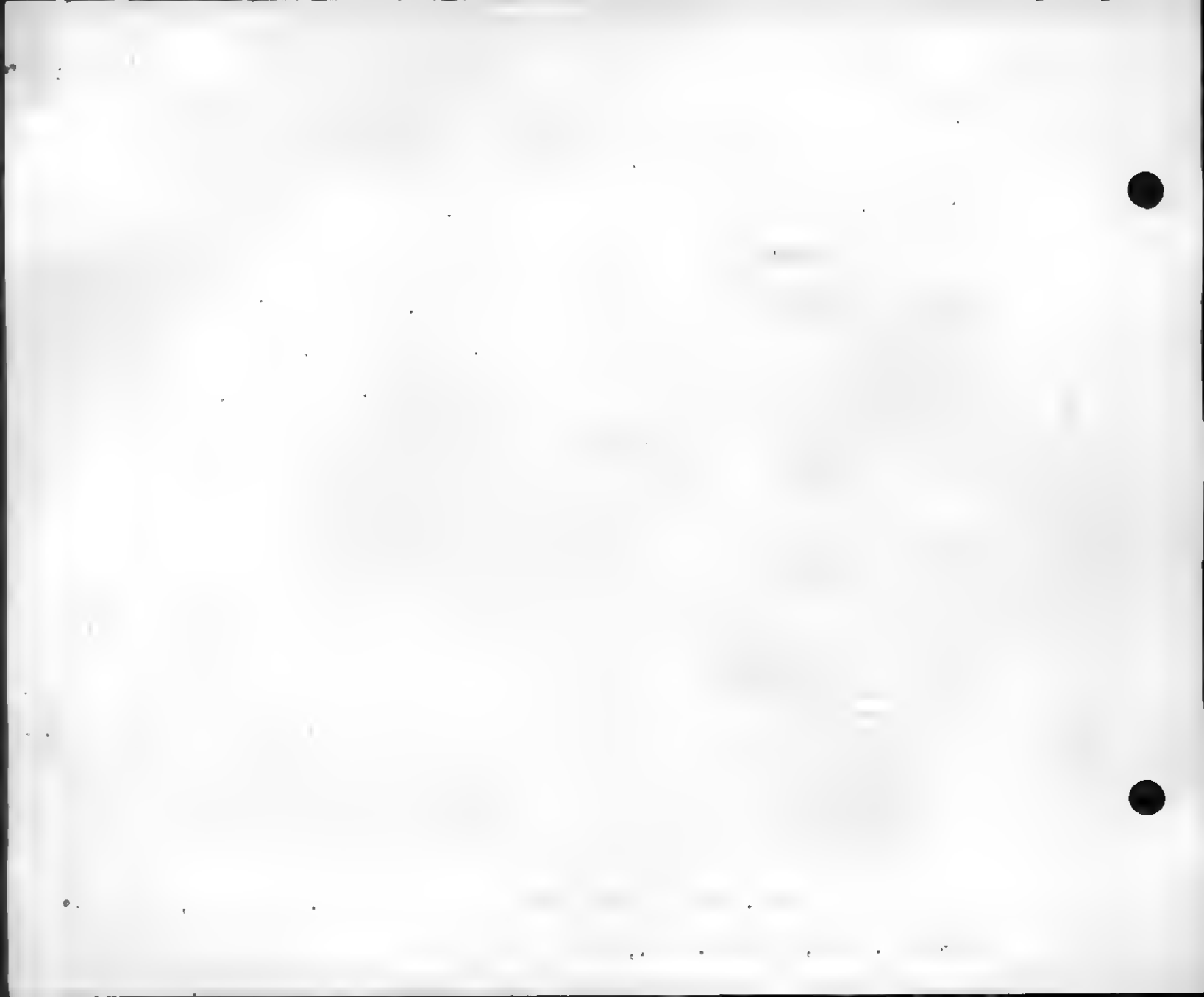


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00186 Item #9 Film #2313 2/10/66 00189  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>ANNA ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town) <b>FT GEO G MEADE MD.</b> c. LENGTH OF STAY IN 1b <b>SIX WEEKS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNA ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FT GEO G MEADE, MD.</b> d. STREET ADDRESS <b>I TRP 11TH ARMD CAV REGT</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FRED</b> Last <b>WATSON</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>21</b> Year <b>19 66</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 DEC 46</b>	9. AGE (in years last birthday) <b>19 20</b> yrs.	IF UNDER 1 YEAR Months <b>19</b> Days <b>20</b> IF UNDER 24 HRS. Hours <b>19</b> Min. <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLDIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US ARMY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>SULLIVAN, TENN.</b>	
13. FATHER'S NAME <b>CLAUDE DOCKERY</b>			14. MOTHER'S MAIDEN NAME <del>NOT AVAILABLE</del> <b>Nannie V. Watson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>225-68-4637</b>		17. INFORMANT Address <b>OFFICIAL MILITARY RECORDS (MR VAN SLIKE)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe head injury</b> <b>8354</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>JEEP ACCIDENT</b>			
20c. TIME OF INJURY Month, Day, Year <b>230 p.m. 21 JAN 19 66</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STREET</b>		20f. (City or town) (County) (State) <b>FT. MEADE ANNA ARUNDEL MD.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>21 JAN 19 66</b> , to <b>21 JAN 19 66</b> , that (I) (we) last saw the deceased alive on <b>21 JAN 19 66</b> , and that death occurred at <b>420</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Douglas D. Strong</b>			22b. DATE SIGNED <b>21 JAN 66</b>		22c. PHYSICIAN'S NAME (Type) <b>DOUGLAS D. STRONG, CAPT MC</b>
22d. ADDRESS <b>KIMBROUGH ARMY HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>26 Jan. 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>COWDEN CEMETERY</b>	
23d. LOCATION (City, town or county) (State) <b>Ft. Blackmore, Virginia</b>					
24. FUNERAL DIRECTOR <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>		25a. REC'D BY REGISTRAR <b>26 JAN 1966</b>		25b. REGISTRAR'S SIGNATURE <i>John W. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>00197</span> <span>Item #9 Film 43312 1/24/66 ne</span> <span>00190</span> </div>											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>						c. LENGTH OF STAY IN ID <u>1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>						d. STREET ADDRESS <u>Arundel-on-Bay-Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>Birdie</u>						4. DATE OF DEATH Last Month Day Year <u>WELLER</u> <u>JANUARY 15</u> <u>1966</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown</u>		9. AGE (in years last birthday) <u>93 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Willie D. Carr</u>						14. MOTHER'S MAIDEN NAME <u>Annie Taylor</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>216-46-6679</u>					
17. INFORMANT <u>Albert A. Whittle-exec.</u>						Address Title Bldg. <u>Baltimore, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia, suspected</u> DUE TO (b) <u>Malnutrition</u> DUE TO (c) <u>Chronic brain syndrome (arteriosclerosis)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 31</u> , 19 <u>65</u> , to <u>Jan 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 15</u> , 19 <u>66</u> , and that death occurred at <u>1:35 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles W. Kinzer</u>						22b. DATE SIGNED <u>Jan 16, 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Kinzer, M. D.</u>						22d. ADDRESS <u>So. River Med Cent, Edgewater, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn Md.</u>			
24. FUNERAL DIRECTOR <u>Dorothy E. Hopper</u>						25a. REC'D BY REGISTRAR <u>JAN 19 1966</u>					
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>											



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FOR STATE  
HEALTH DEPT.

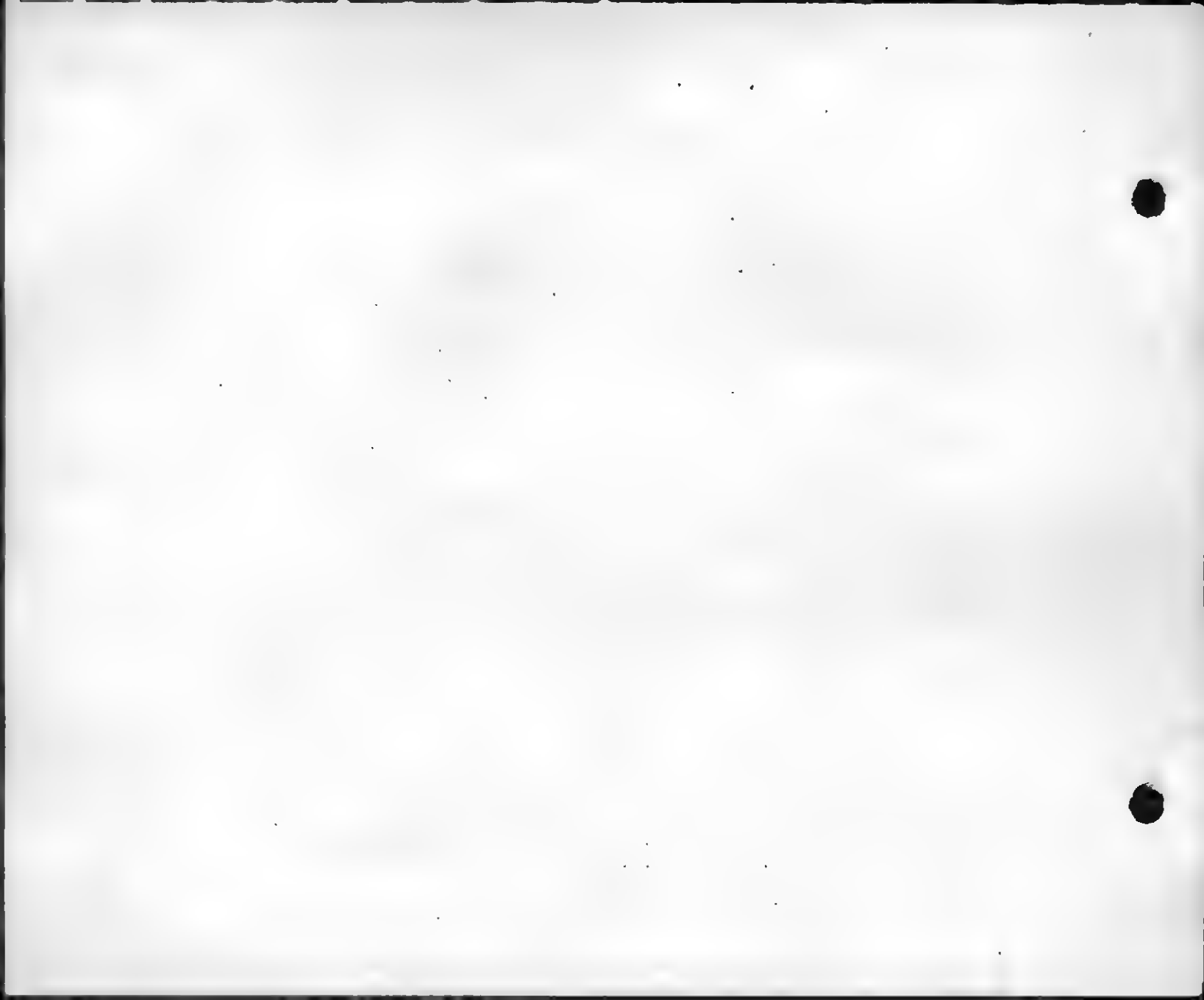
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00198

00191

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN MD d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 7 College Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAMONT		First Middle Last		4. DATE OF DEATH January 20 19 66		Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1965		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chas. Jones				14. MOTHER'S MAIDEN NAME Alberta Williams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Alberta Williams 7 College Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/21/66	
NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-25-1966		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) Annapolis	
24. FUNERAL DIRECTOR William Bennett		ADDRESS Annapolis		25a. REC'D BY REGISTRAR JAN 24 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00199		Item #4 121m #0373 2/12/66 PG						00192			
1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>FANNY</u> First <u>GOTT</u> Middle <u>WILSON</u> Last			4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9-18-1865</u>			9. AGE (in years last birthday) <u>100</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Edwin Gott</u>						14. MOTHER'S MAIDEN NAME <u>Sarah "Unk."</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Richard E. Lankford</u> address <u>Melvin Rd. Annapolis, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypostatic pneumonia</u> <u>522x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>senility</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <u>Dr. Wilson</u> attended the deceased from <u>Jan 29</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>19</u> , and that death occurred at <u>1</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Emily H. Wilson</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-22-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Emily H. Wilson, M.D.</u>						22d. ADDRESS <u>Lothian, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1-22-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>			23d. LOCATION (City, town or county) (State) <u>Tracy's Md.</u>			
24. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons</u>						25a. REC'D BY REGISTRAR <u>FEB 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Burial 4-22-1966 St. James  
John M. Hoffmann

Tracey

Family H Hoffmann

St. James

cc

1-22-66

Supernatural phenomena  
happened

Richard E. Lankford

Sarah "Lut"

Maryland

9-15-1966 100

Gott

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Housewife  
Edwin Gott

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 00200 CERTIFICATE OF DEATH 00193

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b> (Dead on arrival)			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>822 Chester Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Charles</b> Middle <b>Wilmer</b> Last <b>YOUNG</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>28</b> Year <b>19 66</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan. 3, 1880</b>		
<b>9. AGE</b> (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR: Months <b>02</b> Days <b>-1</b> IF UNDER 24 HRS.: Hours <b>00</b> Min. <b>00</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Farm</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>			
<b>13. FATHER'S NAME</b> <b>Daniel Young</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura Formwalt</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs. Mary LeGore, Annapolis, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIOSCLEROTIC HEART DIS</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> <b>5 YRS</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>MAY 1965</b> , to <b>28 JAN 1966</b> , that (I) (we) last saw the deceased alive on <b>27 JAN 1966</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Edward S. Beck</b>			<b>22b. DATE SIGNED</b> <b>1/28/66</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Edward S. Beck, M.D.</b>
<b>22d. ADDRESS</b> <b>73 Franklin St., Annapolis, Md.</b>			<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Jan. 31, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lutheran Cemetery</b>	
<b>23d. LOCATION</b> (City, town or county) (State) <b>Taneytown, Maryland</b>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>C.O. Fuss &amp; Son</b> <b>Taneytown, Md.</b>			
<b>25a. REC'D BY REGISTRAR</b> <b>FEB 1 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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